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ABSTRACT

Appropriate for secondary school social studies, this booklet covers the causes, problems, and possible solutions for the high cost of American health care. The topic is discussed in five sections. The first section, "The $350 Billion Health Care Bill," discusses how the nation's priority on health care has led to the emergence of medicine as America's leading growth industry. "RX for High Medical Bills: More Competition" discusses changes which would encourage consumers and providers to be more cost conscious. "The Government's Role" considers how costs could be confined by redefining that role. "The High Cost of Heroic Measures" questions whether the costs of new procedures are always justified. "Putting a Priority and a Price Tag on Health Care" deals with the need to humanely weigh the costs and benefits of medical care. Two self-administered questionnaires intended for completion before and after participation in a public forum or reading the booklet are included as well as a list of recommended readings. (IS)

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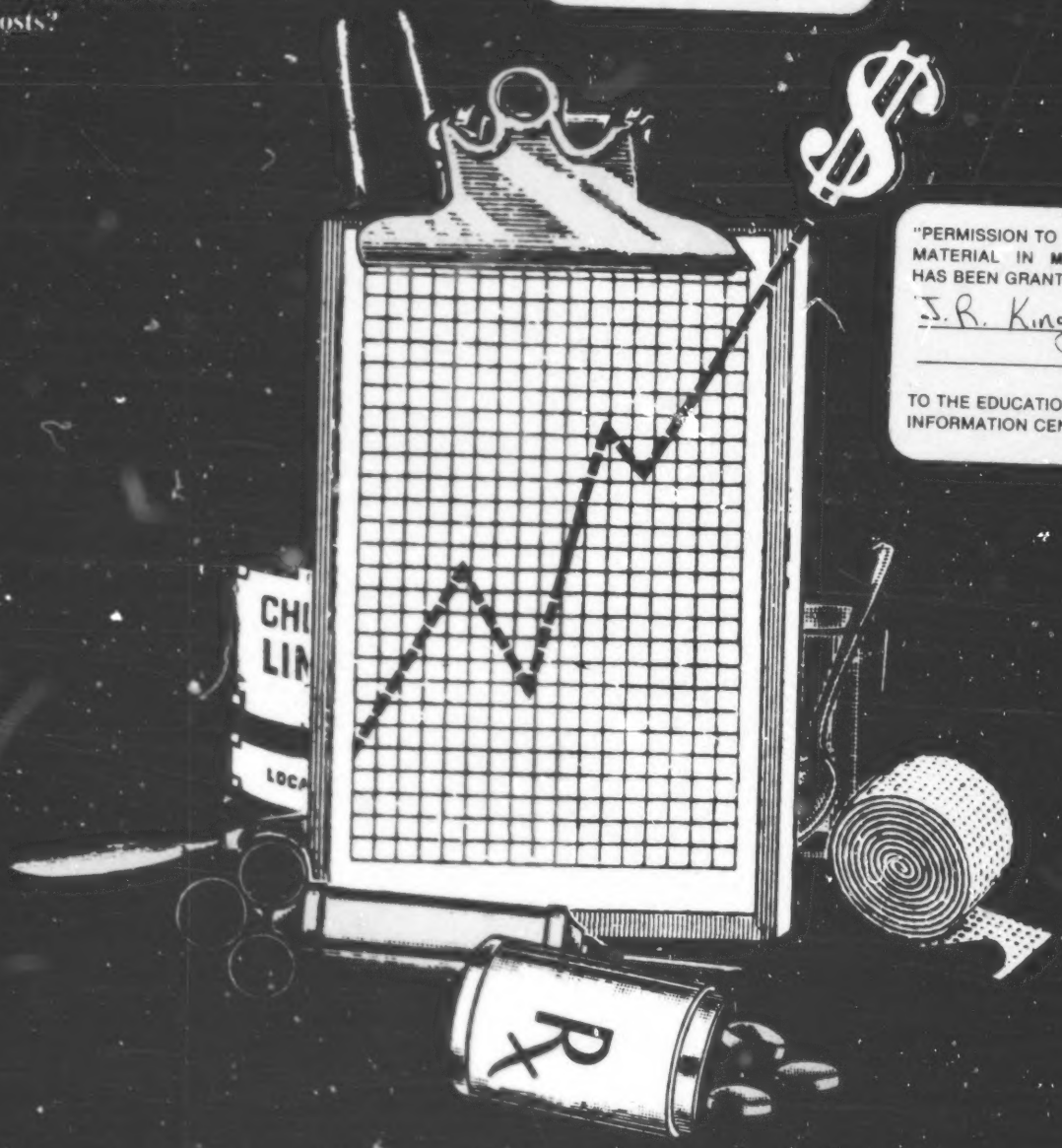
NATIONAL ISSUES FORUM

Health care costs are rising at an alarming rate — faster than any of the other goods or services we consume

★ What can be done to contain health care costs?



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The Soaring Cost of Health Care

As you begin to read this book from the Domestic Policy Association, you are joining thousands of Americans who are participating, in communities all across the country, in the third season of the National Issues Forum. This is a collaborative effort to achieve an ambitious goal—to bring Americans together every year to address urgent domestic issues.

This series was conceived and organized by the Domestic Policy Association, which represents the pooled resources of a nationwide network of organizations—including libraries and colleges, museums and membership groups, service clubs and community organizations. It is an effort that has a special significance in an election year. The Domestic Policy Association does not advocate any specific point of view. Its goal is not to argue the merits of particular solutions, but to stimulate debate about what is in the public interest. The National Issues Forum is not another symposium for expert opinion, or an occasion for partisan politics. Rather, it provides a forum in which concerned citizens can discuss specific public issues, air their differences, think them through, and work toward acceptable solutions.

Each year, the convenors of this nationwide effort choose three domestic policy issues for discussion. This year's topics are environmental protection, health care costs, and jobs and the jobless. These are urgent issues that have been prominent in the news. In each of these areas new realities have to be faced, and important choices made. To address them is to raise serious questions about our values and priorities; they cannot be viewed only from the perspective of particular interests or partisan politics.

There is an issue book like this one for each of the topics. These issue books are intended as a guide to the debate. They provide a menu of choices. Unlike so many partisan discussions, these menus come with a price tag attached.

As the people who have participated in the National Issues Forum over the past two years know, the forum process doesn't begin and end in local meetings. The DPA schedules a series of national meetings each year to convey to elected leaders the views that emerge from these meetings. One of those meetings will take place this coming spring at the John F. Kennedy Presidential Library in Boston. The enthusiastic response to these forums over the past two years indicates that leaders are interested in your considered judgment about these issues. So that your thoughts and feelings can be conveyed in these meetings, we have provided an issue ballot at the beginning and end of this book. Before you begin reading and after you have attended the forums and given some thought to the issue, I urge you to fill out those ballots and mail them back to us.

The Domestic Policy Association's goal is to help citizens engage in discussions about what is in the public interest. As the editor of these issue books, I'm pleased to welcome you to this common effort.

Keith Melville

Keith Melville
Editor-in-Chief
National Issues Forum

Domestic Policy Association
5335 Far Hills Avenue
Dayton, OH 45429

NATIONAL ISSUES FORUM

1. The Soaring Cost of Health Care

One of the reasons why people participate in the National Issues Forum is that they want leaders to know how they feel about these issues. The Domestic Policy Association has promised to convey a sense of your thinking on the topic of health care both locally and at the national level. In order to present your thoughts and feelings about this issue, we'd like you to fill out this short questionnaire *before* you attend forum meetings (or before you read this issue book, if you buy it elsewhere), and another short questionnaire — which appears at the end of this issue book after the forum (or after you've read this material).

The leader at your local forum will ask you to hand in this ballot at the end of the forum sessions. If it is inconvenient to do that, or if you cannot attend the meeting, please send the completed ballot to the DPA in the attached envelope. In case no envelope is enclosed, you should send this ballot to the Domestic Policy Association at 5335 Far Hills Avenue, Dayton, Ohio 45429. A report summarizing participants' views will be available from the DPA next spring.

Part I:

For each item below, check the appropriate box to indicate if it is something

- ☐ we should do *now*
- ☐ we should do *only if* health care costs keep rising faster than inflation
- ☐ we should *not* do under any circumstance

Proposals:	**Should Do Now**	**Only If**	**Should Not Do**	**Not Sure**
A. Introduce more competition into the health care system:				
1. Establish higher deductibles so that patients pay more of their medical bills before insurance coverage begins **PRO:** Would remind people that health care is something we pay for one way or another **CON:** Family budgets could be strained, especially in the short run, and some might put off seeking the care they need	☐	☐	☐	☐
2. Provide workers with a choice of insurance plans and incentives to shop for the insurance they need **PRO:** Would put pressure on insurance companies to be more competitive and offer better values **CON:** Called a "bribe for employees to disinsure themselves" because those who need the money might opt for inadequate coverage	☐	☐	☐	☐
3. Encourage people to join HMOs—Health Maintenance Organizations **PRO:** HMOs have a record of providing good health care for a lower price **CON:** Patients would have to give up their family doctor	☐	☐	☐	☐
B. Limit health care costs through government initiatives:				
4. Regulate costs by imposing limits on how much doctors and hospitals can charge **PRO:** This would be the most direct way to contain costs **CON:** Hospitals and doctors might cut back on the quality of care they provide	☐	☐	☐	☐
5. Make all Medicare and Medicaid recipients pay more of their own bills before coverage begins **PRO:** Would discourage unnecessary use of the health care system **CON:** Might prevent some people, especially the poor, from seeking the care they need	☐	☐	☐	☐
6. Impose higher deductibles on Medicare recipients with higher incomes **PRO:** Fair to make those who can afford to, pay more **CON:** Since we all pay into Medicare, it's not fair for some to get more benefits than others	☐	☐	☐	☐

Proposals:

	Should Do Now	Only If	Should Not Do	Not Sure
7. Require Medicaid recipients to use clinics, HMOs, and other facilities with a record of holding down costs	☐	☐	☐	☐
PRO: Taxpayers should only have to pay for the most efficient forms of treatment **CON:** If the poor are treated differently from everyone else, their care will inevitably become second-rate				
8. Raise taxes to pay the increasing costs of Medicare and Medicaid	☐	☐	☐	☐
PRO: Any cutbacks in these programs would jeopardize peoples' health **CON:** Unfair to raise taxes when many of the elderly can afford to pay more themselves				
C. **Limit heroic measures to contain costs:**				
9. Relax malpractice laws to encourage doctors to perform fewer diagnostic tests and practice less "defensive" medicine	☐	☐	☐	☐
PRO: Both "defensive" medicine and the cost of malpractice insurance add to health care inflation **CON:** Takes away a patient's right to sue, the best protection people have				
10. Define strict criteria about who is eligible for very expensive treatments such as organ transplants	☐	☐	☐	☐
PRO: Those who would derive the most benefit would still get these procedures **CON:** Some people will be deprived of life-saving care				
11. Put strict limits on hospitals' ability to buy expensive technology such as CT scanners	☐	☐	☐	☐
PRO: Such equipment is usually available in nearby hospitals **CON:** Such equipment might not be there for those who need it				

Part II:

Indicate whether you favor or oppose each of these measures.

	Favor	Oppose	Not Sure
12. Institute a national health insurance program that would guarantee health insurance for all Americans	☐	☐	☐
13. Expand Medicare to provide catastrophic illness protection to all recipients	☐	☐	☐
14. Expand Medicare to cover the cost of prescriptions, eyeglasses, and hearing aids	☐	☐	☐

Part III:

Background Questions

15. Did you participate in a DPA forum last year?

Yes ☐
No ☐

16. Did you (or will you) participate in DPA forums on other topics this year?

Yes ☐
No ☐

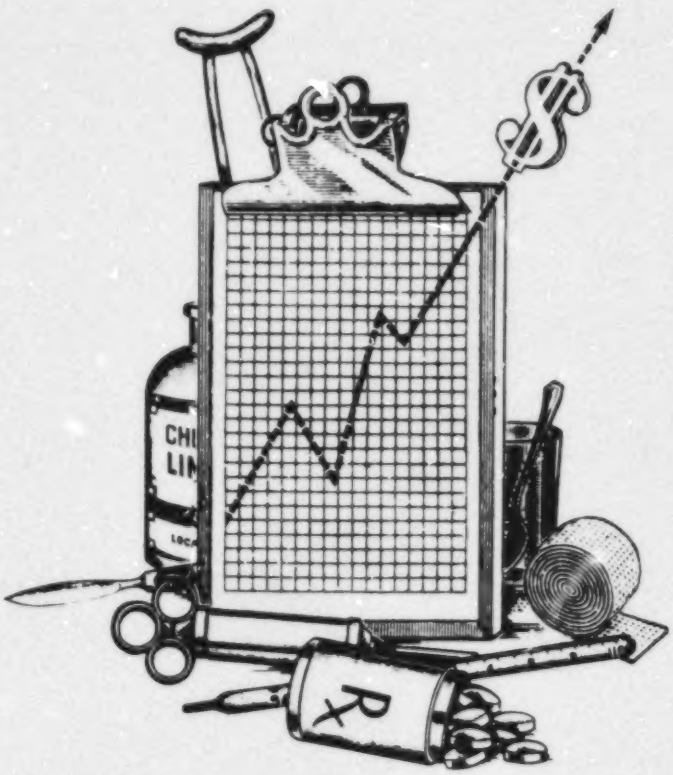
17. Which of these age groups are you in?

Under 18 ☐
18 to 29 ☐
30 to 44 ☐
45 to 64 ☐
65 and over ☐

18. Are you a man or a woman?

Man ☐
Woman ☐

NATIONAL ISSUES FORUM



The Soaring Cost of Health Care

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THE DOMESTIC POLICY ASSOCIATION

The Domestic Policy Association is a nonprofit, nonpartisan association devoted to raising the level of public awareness and discussion about important public issues. It consists of a nationwide network of institutions — colleges and universities, libraries, service clubs, membership groups, and civic organizations — that bring citizens together to discuss public issues. The DPA represents their joint effort to enhance what they already do by working with a common schedule and common materials. In addition to convening meetings each fall in hundreds of communities in every region of the country, the DPA also convenes meetings at which it brings citizens and national leaders together to discuss these issues and the outcome of community forums.

Each year, participating institutions select the topics that will be discussed in the Issue Forums. On behalf of the Domestic Policy Association, the Public Agenda Foundation — a nonprofit, nonpartisan research and education organization that devises and tests new means of taking national issues to the public — prepares issue books and discussion guides for use in these forums. The Domestic Policy Association welcomes questions about the program, and invites individuals and organizations interested in joining this network to write to: The Domestic Policy Association, 5335 Far Hills Avenue, Dayton, Ohio 45429.

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Alarmed at the result of writing a blank check for the health care industry, many people advocate changes that would encourage consumers as well as providers to be more cost conscious.

3 **The Government's Role: Redefining Benefits, Regulating Prices** 15

Although ours is a private health care system, the government plays a major role in it. Many people are convinced that costs could be contained if the government's role were redefined.

4 **The High Cost of Heroic Measures** 24

New diagnostic and surgical techniques allow doctors to do far more than they formerly could. But are their high costs justified by the results?

5 **Putting a Priority and a Price Tag on Health Care** 32

Thinking about what is in the public interest requires both patients and health care providers to weigh in a humane fashion the costs and benefits of medical care.

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The $350 Billion Health Care Bill

> **"This nation has put a priority on health care, and as a result this has been America's leading growth industry. The question is how to curb its appetite for additional resources."**

This past January, Margaret Heckler, Secretary of the Department of Health and Human Services, called a press conference to present a report on the nation's health. Pointing to charts that showed improvements in life expectancy, infant mortality, and the death rate attributed to heart disease, she asserted that "the nation's health is better than ever. We are living longer, we are living healthier, and we are providing the benefits of our unparalleled health care system more widely and more equitably."

There is no question that America's health care system is impressive. For the past decade, it has been the country's leading growth industry. That expansion began in the immediate postwar years, when there was a widespread sense that too little was being done to provide for the nation's health, that more of our resources as a nation should be devoted to medical research, the training of doctors, and the construction of new health care facilities. We were becoming a more prosperous nation, and many people felt that some of the fruits of that prosperity should be spent to improve the nation's health.

Expenditures in the area of health began to increase steadily, from 4.4 percent of the gross national product — the total amount spent on goods and services — in 1950 to 7.6 percent in 1970. Today, in 1984, the share of the gross national product devoted to health care is more than 10 percent. Which is to say that one dollar out of every ten that we spend in this country goes toward protecting our health or seeking medical treatment. That amounts to more than $350 billion a year.

As Mrs. Heckler's charts showed, the increasing share of the nation's wealth devoted to health care over the past four decades has led to some real improvements. Life expectancy for Americans has risen from 63 years to more than 74 years. Infant mortality has been reduced by more than half over the past twenty years. There is now an intensive care burn unit for every one million Americans, compared to one unit for every twenty million Americans just two decades ago. There has been a similar increase in the number of specialized coronary care units. There have been breakthroughs in diagnostic technologies — such as CT scanners, which reduce the need for risky and costly exploratory surgery. The use of antihypertensive drugs has brought about a drastic reduction in both death rates and severe complications from high blood pressure. Since 1970, as Mrs. Heckler remarked, there has been an "amazing" 40 percent drop in the death rate from strokes. In brief, the nation's investment in health care has helped to extend the lives of millions of people, and it has improved the quality of life for millions more.

Extending Health Insurance Coverage

One of the most significant changes since the postwar years is in the number of people who can afford quality health care. In 1950, only half of the American people had adequate insurance

for hospital-related expenses. Since then, the percentage of Americans covered by private health insurance policies has increased very rapidly, to the point where most of the working population and their families are protected.

In 1965, President Johnson signed legislation designed to provide health insurance for two groups that are often not covered by private health insurance plans, the poor and the elderly. Medicaid, a program to which both federal and state governments contribute, provides medical service for the poor. Medicare pays for most of the medical costs of those over 65 — people who typically have only a modest income but high health care costs. In 1972, Medicare coverage was extended to the severely disabled and the blind, and later to those requiring kidney dialysis and kidney transplants.

Thanks to these programs, many Americans have been able to benefit from high-quality medical care, regardless of their personal wealth. This has been especially true for people with life-threatening medical conditions, such as kidney failure. As recently as fifteen years ago, most victims of kidney failure simply died. Today, Medicare pays most of the bill for dialysis. Because of medical innovations such as cataract surgery, artificial joints, and heart pacemakers, which Medicare pays for, many people are now able to live happily and productively until well into their 80s. The Medicaid program has been somewhat less successful. As Mrs. Heckler pointed out, there is still a "distressing" burden of death and disease among the nation's poor. Blacks and other minority groups suffer a "persistent and continuing disparity in the burden of death, illness and disability." But, as she put it, "the situation is improving. We are making progress."

In all, over the past generation, many Americans have gained protection from the potentially severe financial burden of seeking medical treatment. Through private insurance plans or government-provided health care plans, most people are now insulated from the cost of medical care at the time it is needed.

Soaring Costs

But there is a problem — and the problem is money. In recent years this nation has been discovering the high cost of extending health care protection to such a large portion of the population. Consider what has happened with the Medicare and Medicaid programs. Like many other entitlement programs, their actual expense has far exceeded projected costs. Take Medicare, for example. When Congress first passed the Medicare program, which entitled everyone over 65 to hospital care, it was estimated that Medicare would cost $8.8 billion by 1990. Expenditures passed that figure in 1973, only eight years after the program began. They doubled between 1974 and 1979, and again by 1984.

The question now is whether Medicare will be bankrupt by 1990. The program's trustees recently reported that the

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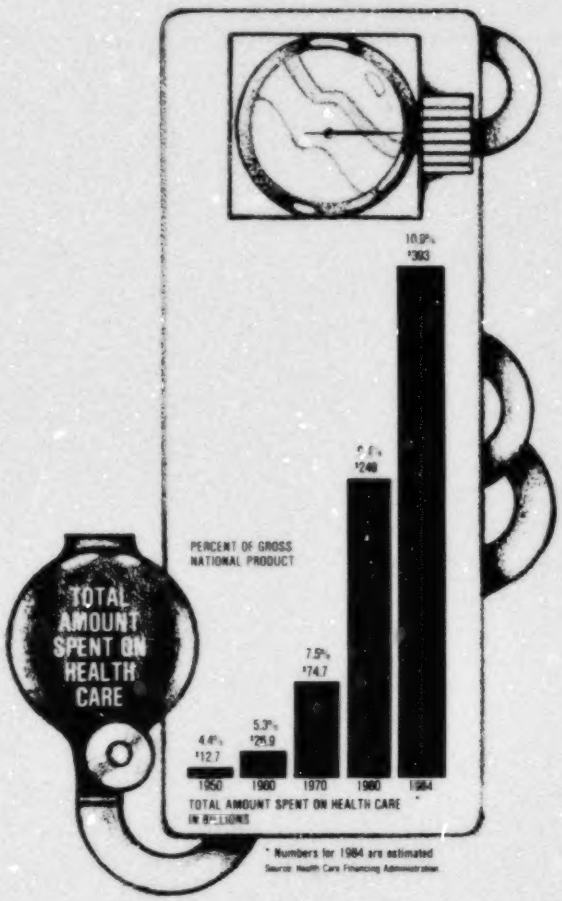
"The nation's health is better than ever. We are living longer, we are living healthier, and we are providing the benefits of our unparalleled health care system more widely and more equitably."
— Margaret Heckler

Soaring Costs of Health Care



"Over the past two decades, the nation's medical care bill has grown more than tenfold — from $27 billion to more than $350 billion. Unless changes are made, we will continue to spend more and more on medical care."

hospital insurance fund will be exhausted by then if existing laws are not changed. Congress must decide whether to increase taxes in order to pay the high cost of Medicare — and of Medicaid, which faces a similar problem — or to reduce benefits.

But the crisis of the Medicare system is merely a reflection of the larger problem of health care cost inflation. Several startling statistics indicate how fast these costs have been accelerating. Over the past two decades, the nation's medical care bill has grown more than tenfold — from $27 billion to more than $350 billion. The cost of an average stay in the hospital has soared from about $670 in 1971 to more than $2,000 today. While the rate of increase in health care costs has slowed down somewhat recently, costs continue to grow at a rate that is far higher than the rate of inflation. It seems clear that unless changes are made, we will continue to spend more and more on medical care — and as a consequence limit what is available for *other* social goods.

It is not just the federal government that is caught in the pinch of escalating health care costs. Consider the problem facing the Chrysler Corporation. This year, American business will spend $70 billion on health insurance. The portion of it that Chrysler will spend is roughly $400 million, which adds about $600 to the cost of every car the company manufactures. The company has unusually generous benefits, and pays benefits to an unusual number of retired workers, so Chrysler's costs for insurance premiums are higher than most companies pay, about $6,000 per employee, which is three times the national average. But the crunch that the company feels is typical of the situation of American business in general. Chrysler's problem is the result of the same forces that have led to the crisis of the Medicare system.

In the 1950s and 1960s, Chrysler Corporation — like the American economy as a whole — was doing quite well. As Chrysler's current chairman, Lee Iacocca, recently remarked, "We were a golden goose business. We were rich, fat and sloppy. Health care costs weren't so great then, and the company was making a ton of money." So, like the other major automobile manufacturers, Chrysler agreed to a generous health insurance policy which covers the entire cost of hospitalization and medical tests, and most of the cost of outpatient dental, psychiatric, vision, and hearing care. For retired workers and their spouses, the company's insurance plan pays almost everything that isn't covered by Medicare.

Then, in the mid-1970s, insurance premiums for health care started to rise. By the late 1970s, for Chrysler and many other American firms, the cost of medical insurance was rising faster than any other major business expense. Understandably, Chrysler's employees weren't about to agree to modifications. They argued that health benefits were a right they'd won through collective bargaining. As union head Douglas Fraser put it, "Health benefits are sacred ground." Today, Chrysler, like Ford and General Motors, is planning in its next contract negotiations

to ask patients covered under its medical plan to pay part of their expenses for doctors and hospitalization. But that change is regarded as nothing more than a stopgap measure. As company chairman Lee Iacocca warns, if the nation's health care system isn't revamped, "you're going to see a lot of broke companies."

The Third-Party Health Trap

Who pays the $350 billion health care bill? Patients and their families pay only a small part of it directly. On the average, the public pays only about 30 cents of every health care dollar out of its pocket, and even less (about ten cents on the dollar) for hospital cost. Most of those costs are paid for by Medicare and Medicaid, and private health insurance plans. In other words, a large part of the health care dollar, and about 90 percent of the cost of hospital care, comes from "third-party" payers — and not directly from the pockets of patients who receive care.

Because we're insured, we tend to think of health care costs as what we pay out of our own pockets — for an office visit, for a prescription, for our share of a hospital bill. But the truth is that one way or another, the average family *does* end up paying a large share of the total health care bill. We pay through our share of federal taxes that support the costs of the Medicare and Medicaid programs. We pay through our share of state and county taxes to support public hospitals and other community health needs. Because health care costs push up the cost of doing business, we pay indirectly through higher prices for goods and services. This indirect payment comes about because our employers pay for medical insurance. Some of the money used for that purpose might otherwise come to us in salary. Some might be used to expand local businesses or to provide new jobs. We pay in other, less obvious ways, too. The cost to the U.S. Treasury of allowing employers a tax deduction on medical premiums amounted to some $25 billion last year. That's $25 billion in lost revenues, tax dollars that might have been spent for other purposes.

If you add up only the direct payments that we make for health care, for our private health insurance, and for our taxes that pay for medical services, the annual health care bill for every adult in America comes to about $2,000 — or more than $4,000 per year for each family.

Are Health Care Costs Out of Control?

The reason why there's so much concern about health care costs is that they're very likely to continue their upward spiral. The revolution in medical technology that has pushed costs upward shows no sign of abating. Over the next two decades, the number of Americans over 65 will double. Since medical care for the elderly costs more than it does for the rest of the population, this increase in the number of older Americans will push costs still higher. So, while there is widespread agreement that pro-

What Do You Pay Each Year for Health Care?

Because most of us are insured, we think of health care costs as what we pay out of our own pockets — for an office visit, for a prescription, for our share of a hospital bill. But we really pay much more than that. Here is what the health care bill for the nation is expected to look like in 1984.

What You Pay

There is our share of federal funds used to pay for Medicaid, Medicare and other national health programs. That averages out to about $660 each year for every adult **$660**

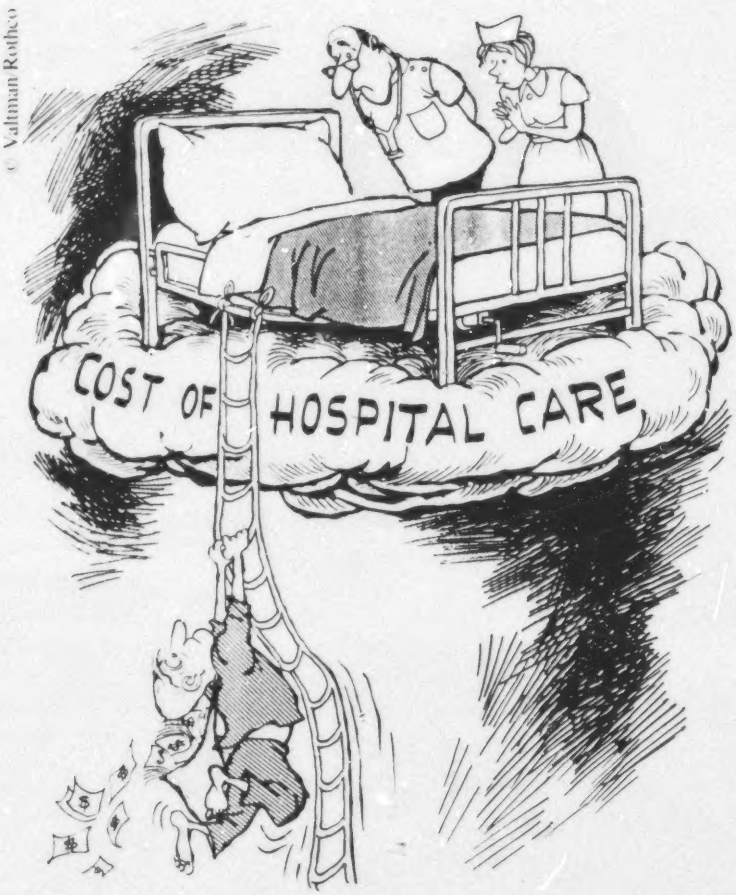
There is our share of state and county taxes to pay for public health programs and facilities.
That is about $288 each year for each of us **$288**

There's the money our employer pays for medical insurance. Some of that money might be coming to us in salary. And some of it might be used to expand local businesses and provide new jobs.
That comes to $592 per adult **$592**

Then there's what we pay directly. On the average, that's $626 ..... **$626**

In 1984, it is expected to add up to $2,166 for every adult **$2,166**

Source: Costs are estimates for 1984 based on figures from the Health Care Financing Administration.



"Over the past few years, a lively debate has begun about how to contain health care costs. The debate will influence decisions that affect the well-being of more than 230 million Americans."

viding high-quality medical care must be one of this nation's priorities, there is a growing sense that some alternative has to be found to control the way in which health care is currently delivered and financed. In this book, our purpose is not to examine all of the factors that contribute to health care costs, nor to assemble a list of "villains" on whom the problem can be blamed. Our aim is rather to examine some of the proposed solutions, and to provoke debate about them.

Some people believe that the problem could be solved by controlling unnecessary lab tests or excessive hospital admissions. But it is unrealistic to expect that it can be solved painlessly. To make a dent in the nation's health care budget, we will have to cut meat along with the fat.

Over the past few years, a lively debate has begun about how to contain health care costs, a debate that involves many of the interested parties — hospital administrators, physicians, insurance companies, labor unions, business, and government. Different options are being proposed, and some decisions are being made. Both the administration and state legislatures have proposed health care cost-containment legislation. Some states have taken measures to cut people from the Medicaid rolls, or to reduce the number of services covered by that program. Companies are trying to reduce their health care insurance costs by pressing workers to pay a larger share of their own medical bills.

The purpose of this book is to provide a framework for discussion. In the following sections we will examine three distinctive approaches to cost cutting. The first is to encourage more cost consciousness on the part of both health care consumers and providers. The second is to reduce the cost of publicly subsidized health care programs. The third is to cut costs by rationing certain types of medical care. Each of these measures would result in significant savings. But each would also deny some potentially beneficial services to some patients. These are decisions that affect the well-being of more than 230 million Americans, which is why it is essential that the public join in the debate.

RX for High Medical Bills: More Competition

> **"Alarmed at the result of writing a blank check for the health care industry, many people advocate changes that would encourage consumers as well as providers to be more cost conscious."**

Think for a moment about what you'd do if you were interested in buying a new car. Because this is a "big-ticket" item, one of the largest purchases that most families make, you'd probably be careful to make sure that you get your money's worth. First of all, you'd figure out how much you're able to spend on a car. You'd have a pretty good idea of the kind of car you need, as well as the make that you like. Knowing that prices vary from one dealer to another, you'd probably shop around. Salesmen might try to convince you to buy the top-of-the-line model, and more accessories than you need. But you know that you have to be realistic. After all, you're going to have to pay for it.

Another "big-ticket" item in every family's budget — their share of the nation's health bill — costs, on average, just about what it costs per year to own and operate a car. But the contrast between the way most people shop for a car and the way they "shop" for medical care could hardly be greater.

Even the most intrepid shoppers, people who take more pleasure out of getting a bargain than they do from the purchase itself, leave their copies of *Consumer Reports* and their habit of comparison shopping at the door when they enter the doctor's office. The same consumers who shop furiously for the best bargain on station wagons and Cuisinarts report dutifully to whatever hospital their physician sends them for tests and treatment. Most of us don't even ask what each test will cost, or whether we really need to spend one more day in the hospital.

The reason for the difference isn't hard to understand. When you buy a car, you pay for what you order, every penny of it. But when you receive medical care, a large part of the costs are paid by someone else.

For some 50 million people who qualify for Medicare or Medicaid, the costs are subsidized by the government. For some 180 million Americans who are privately insured by Blue Cross, Blue Shield, or any of the 200 other commercial insurers, the costs are subsidized by all of the people who participate in the plan. The payment for one party (the patient) to another (the hospital) by a third party (the insurance firm or the government) is called a "third-party payment." Because such third-party payments cover 90 percent of the cost of hospital bills, out-of-pocket costs are fairly modest. With that subsidy, most people choose to buy far more expensive care than they would if they were not so well insured. Think of the kind of car you'd buy if you had to pay just ten cents out of every dollar of its price.

Because of those third-party payments, most of us have no more than a modest financial stake in the decisions made about our care. If we *were* cost conscious — if we went to doctors who charge less, for example, or to hospitals whose rates are lower — that behavior wouldn't be rewarded. For example, a Medicare beneficiary who chose a lower-cost health care option would not receive a dime from the savings. Furthermore, in most companies employees have no choice

among insurance policies, nor do most people know what their insurance plan costs.

But the fault doesn't lie just with consumers. None of the other parties in the health care delivery system have had reason to be cost conscious either. Since physicians and hospitals are assured of payment regardless of the cost, they are happy to oblige the public in its demands for the best service. Physicians typically exercise little restraint over the goods and services that they order in the course of treatment. Critics charge that this attitude leads to far too many laboratory tests, the overuse of expensive new technologies, and hospital stays that are longer than necessary. Physicians respond that an additional test or treatment *might* help. They argue that the highest ethical imperative of the medical profession is not to keep costs down but to do everything possible for the patient. Critics respond that "everything possible" may be very costly indeed.

Until Congress recently approved a new Medicare reimbursement scheme which sets limits on the fees it will reimburse for each diagnostic category, Medicare — like Blue Cross — reimbursed health care institutions on the basis of their costs, so it wasn't in the hospitals' interest to economize. Under that system, any hospital that reduced its costs would reduce its income. So hospitals typically solved their financial problems not by economizing but by maximizing reimbursements.

A third-party payment system which offers reimbursement on a cost-plus basis has protected individuals against the high costs of health care, and provided ample funds to health care institutions. But in doing so it has created a serious problem for the entire society. "The health care industry," says Alain Enthoven, an economist who specializes in this area, "is a classic example of market failure. We have allowed it to evolve in a direction in which waste, overuse, and an upward spiral of fees are encouraged, while efficiency and economy are discouraged."

"The health care industry is a classic example of market failure. We have allowed it to evolve in a direction in which waste, overuse, and an upward spiral of fees are encouraged, while efficiency and economy are discouraged."
— Alain Enthoven

Over the past few years, many people have argued that the best way to contain health care costs is to set in motion forces that we normally take for granted in free markets. In this view, the best way to contain soaring health care costs is to take advantage of people's inclination to get the most for their money, and to encourage providers to compete with each other to lower the costs.

Various proposals have been made under the banner of competitive health care. Essentially, these plans are different ways of accomplishing three related goals, each of which is important if consumers are to be persuaded to be more cost conscious and health care providers more competitive. First, consumers must have a personal financial stake in reducing health care costs. Second, they must be urged to shop around, to choose from among competing health care plans. Finally, they must have lower-cost alternatives to choose from.

Let us examine alternatives designed to accomplish each of these goals, and explore their likely impact.

A Personal Stake in Reducing Costs

That so many Americans have health care insurance today represents a major accomplishment and a significant change from the situation that existed as recently as the 1950s. It is not just that more Americans are covered than ever before; health insurance has also become increasingly comprehensive. Rather than providing protection chiefly against large and unexpected medical bills, health insurance routinely pays for relatively minor expenses such as eyeglasses and regular dental care. Over the past two decades, many employers have substantially reduced or eliminated the deductibles and coinsurance paid by their employees.

It is easy to understand why employees and their representatives in collective bargaining have so eagerly sought comprehensive medical insurance. Considering the high cost of medical treatment, we want all the insurance protection we can get. It is understandable, too, why employees have so frequently opted for more comprehensive insurance rather than for the largest wage hikes they could get. One of the major inducements to the purchase of health insurance is the tax sub-

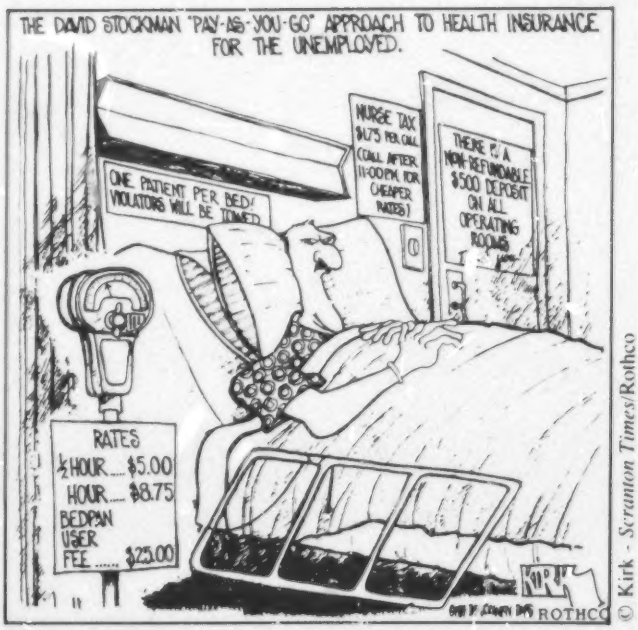
sidies that are available for this purpose both to employers and individuals. Employers can deduct much of the cost of what they pay toward health insurance from their taxes. Many individuals deduct as much as half of the amount they pay for health insurance premiums. In addition, employer-provided health insurance is not counted as taxable income. As a result, each dollar that an employer spends on health care insurance buys about 50 percent more in health care services than it would if the dollar had been paid in additional wages to workers, who could then purchase their own insurance. These tax policies — which in fact are a form of subsidy — have encouraged employees and their unions to choose more comprehensive insurance rather than higher wages.

By subsidizing the purchase of health insurance, the government has encouraged more comprehensive insurance, including "first-dollar" coverage — which is to say that patients are required to pay only a nominal fee, or nothing at all, before they receive health insurance benefits. By providing such coverage, insurers have in effect issued an invitation to consumers to disregard the cost of health care. As a consequence, consumers have no reason to think twice about visiting the doctor, no incentive to seek less expensive care. It has become a vicious cycle, a self-perpetuating process: the high cost of care induces families to get more comprehensive coverage; with more comprehensive coverage people use the health care system to a greater extent; which encourages hospitals to produce more services; and that, in turn, makes comprehensive coverage even more attractive.

Critics of this system argue that it represents the triumph of good intentions over common sense and that any serious effort to contain spiraling health costs must begin with its alteration. If consumers had higher deductibles, they'd cut down on unnecessary visits to the doctor and shop around more carefully for medical services.

Several recent proposals from employers and the government have focused on increasing the deductible. Many corporations have recently raised the portion of the medical bill that employees are required to pay, and others are planning to do so. Employers argue that the $50 deductible — a common feature in many programs — was put into effect in the 1950s, when it represented a substantial amount of money, roughly what it cost for a two-day stay in the hospital. A deductible equivalent to the cost of a two-day hospital stay today would amount to more than $500. Employers say that they are just belatedly adjusting for the effects of inflation.

An innovative variation on this approach provides cash benefits that may add up to several hundred dollars per year for employees who don't go to the hospital or call on their doctor. In Mendocino, California, "stay well" accounts have given some 2,500 school employees a stake in their health care expenditures. As one teacher remarked, with a "stay well" ac-


THE DAVID STOCKMAN "PAY-AS-YOU-GO" APPROACH TO HEALTH INSURANCE FOR THE UNEMPLOYED.
ONE PATIENT PER BED! VIOLATORS WILL BE TOWED
NURSE TAX $4.75 PER CALL (CALL AFTER 11:00PM FOR CHEAPER RATES)
THERE IS A NON-REFUNDABLE $500 DEPOSIT ON ALL OPERATING ROOMS
RATES
½ HOUR ... $5.00
HOUR ... $8.75
BEDPAN USER FEE $25.00
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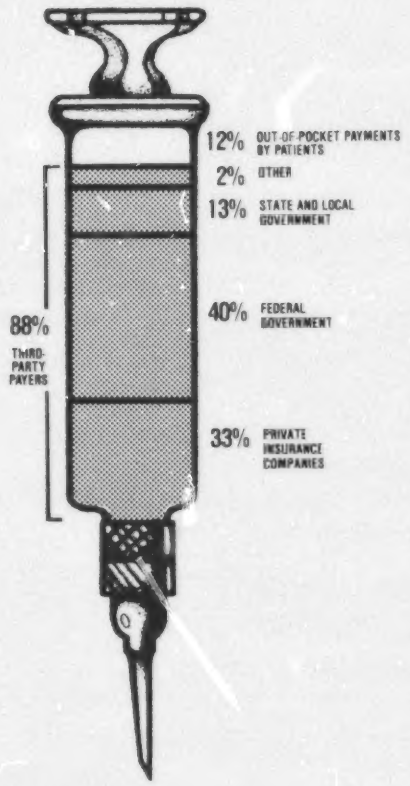
Some people fear that if medical services are regarded as other commodities in the marketplace, patient care will suffer.

Who Pays for Hospital Care?



"For the past 30 years we've come up with bigger and fancier benefit packages. The public has responded predictably by saying, 'We paid for them. Now let's use them.'"
—James Anderson

count, "you think twice about running to a doctor when you have a sore throat."

But plans to give people a stake in health care costs have proved to be very controversial. Critics fear that it will prompt some people to seek lower-quality care or to avoid treatment that they need. They have spoken out against higher deductibles and "stay well" accounts on the ground that they encourage people to play "Russian roulette" with their health. Higher deductibles might cause families to postpone spending $50 to see a specialist about a troublesome mole, delay treatment of a youngster's earache, or skip dental X rays. Such actions, they point out, could lead to far more serious and expensive medical problems down the road. Advocates of these plans maintain that the services people choose to pass up are unnecessary.

To proponents of a more competitive health care system, the argument for higher deductibles (and co-payments where patients pay a certain percentage of the fee) is both simple and compelling. As well-intentioned as the efforts to insulate patients from the costs of medical care have been, such features as first-dollar coverage and low co-payments have encouraged millions of Americans to disregard health care costs. And as long as most people have no incentive to economize, they're going to keep making more demands on the health care system — and we'll all end up paying the huge bill that results.

You'd Better Shop Around

A second proposal would make the health care system more competitive by encouraging people to seek out the care that gives them the most for their dollar. Currently, employees are typically passive recipients of health care insurance and medical services. Reformers point out that the entire system would be more competitive if consumers were offered a choice of plans, and an incentive to shop for the best health care value. Employers could offer a choice among various plans, and then make equal dollar contributions toward any option that employees choose.

This is what is taking place in such firms as Alcoa, Quaker Oats, B. F. Goodrich, and the Polaroid Corporation. Rather than providing a specific health insurance plan for employees, these companies lay out several possibilities and offer health care reimbursement accounts that can be applied to any of them. For example, employees at the Polaroid Corporation in Cambridge receive a detailed brochure that describes nine different health plans serving the area. The company contributes a fixed amount each month — $133 for each worker with a family. Employees must choose a plan that covers the cost of catastrophic illness. But with that exception, they are free to pick the plan of their choice. Some of those plans are more extensive

than others, some cover the costs of doctor's visits while others do not, some include first-dollar coverage while others have a relatively high deductible. But with a health care reimbursement account, you are free to choose among the various plans to find one that suits you best. If you choose a plan that costs more than your company's contribution, you would have to make up the difference. If you choose a plan that costs less than that monthly figure, you pocket the difference.

The whole point of encouraging health care consumers to shop around in this way is to put pressure on doctors and hospitals to keep their costs down. It seems to work. People who purchase their own health care plans have an incentive to comparison shop for the best value, and that puts pressure on insurance companies to control their costs to keep their rates competitive. This in turn puts pressure on physicians and hospitals to invest only in facilities and equipment that enhance their ability to offer care at reasonable cost.

As appealing as health care reimbursement accounts may sound, this approach has its opponents. Such initiatives have been labeled "a bribe for employees to disinsure themselves."

Alternatives to Fee-for-Service Medicine

The two proposals that we have just considered promise to make the health care system more competitive by giving consumers a financial stake in health care decisions that affect them. A third proposal would reduce costs by changing the way in which medical services are delivered.

Traditionally, American medical practice was organized around physicians in private practice and nonprofit hospitals. But over the past few decades there have been some striking changes in both of these areas. Group practice has grown to the point where about one in four physicians works in an arrangement with other doctors. Even more striking is the change in hospitals. One out of eight hospital beds in this nation is now provided by a profit-making hospital chain.

What has not changed very much is the so-called fee-for-service payment system in which doctors are paid for each service they provide, each medical intervention they perform. This system, critics contend, is the barrier that stands between us and more cost-effective health care. What every community needs, they argue, is an alternative to the traditional delivery of medical services, one that makes a variety of medical services available under one roof, and one that offers comprehensive medical care, including the preventive care that doctors often slight — all for a fixed amount, paid in advance. Such prepaid plans which offer a full range of health care services are now called Health Maintenance Organizations (HMOs). Actually, prepaid health services have been around for years. One of the earliest — the Kaiser-Permanente Medical Care program that was initiated in 1938 for workers on the Grand Coulee Dam — is today the largest medical provider of this sort.

Because care is paid for in advance, HMOs have no incentive to offer diagnostic tests that may not be necessary, to provide superfluous services or to recommend unnecessarily long stays in the hospital. In short, because they are not reimbursed on a procedure-by-procedure basis, HMOs have a strong incentive to keep costs down.

In addition, while doctors customarily treat patients on an episodic basis, when specific medical symptoms occur, HMOs, because they operate on a fixed-fee basis, assume a continuing responsibility for care, and place more emphasis on preventive services. They typically provide flu shots, for example, and annual checkups as a way of minimizing future costs.

Statistics suggest that medical costs for people enrolled in HMOs are lower than they are for people with conventional coverage. People enrolled in California's Kaiser plan, for example have health care costs that are 10 to 40 percent lower than for people with conventional coverage.

How are those savings achieved? Because HMOs have an incentive to choose less costly modes of treatment, they less

"$1500 for everything... and that's my final offer!"

How absurd it sounds — a consumer of medical care who's actually concerned about the price!

But while he may be greeted with amazement by the hospital staff, it isn't really *be* who's amazing — it's the rest of us, who've been buying health care as if money grew on trees.

Courtesy of AEtna Life and Casualty

"Many people have fundamental reservations about trying to keep costs of health care down through 'pro-competitive' measures. They argue that the marketplace is a cold arena for people who are sick and vulnerable, and unable to make the calculations that the market demands."

often admit patients to hospitals and more frequently resort to treatment on an outpatient basis. Patients who receive care through HMOs also take fewer diagnostic tests and have markedly lower surgical rates.

Costs are lower in HMOs for another reason too. If you belong to an HMO, you are likely to be assisted by a variety of health professionals who do not have the intensive training in specialty care that doctors receive, but who are well qualified to provide primary, preventive, or emergency care. In HMOs, these "physician extenders" — who include nurse clinicians, pediatric assistants, or physicians' assistants — work under the guidance and supervision of physicians. It is through such measures that HMOs promise to increase access to medical care while lowering costs.

As health care costs have accelerated over the past decade, interest in HMOs has grown considerably, especially among corporations searching for a way to contain their costs. Nationally, more than 10 million people are now enrolled in HMOs. Still, growth in enrollment has been relatively slow, partly because many people are reluctant to leave their personal doctors. This reluctance reflects one of the chief criticisms of prepaid plans, that they take away one's freedom to choose a personal physician. People who receive their health care through HMOs are not free to seek out a specialist when they have a particular ailment. Nor can they go to a particular hospital if it offers something that they particularly want. Advocates of HMOs respond that in a medical emergency your family physician would very likely send you to a particular hospital, or refer you to a specialist anyway. Nonetheless, many people are reluctant to sever their relationship with a doctor who provides more personal assistance than they might receive at an HMO.

One of the growing concerns about HMOs is that many of them are being converted into for-profit operations and combined into national health care firms. Even some of the early advocates of HMOs have reservations about whether for-profit health care centers managed by national corporations can maintain high professional standards and provide quality care. Questions have also been raised as to whether HMOs are likely to serve poorer communities and patients with severe medical problems.

Health Care in the Marketplace

The various proposals that have been made in the name of erecting a more competitive health care system raise fundamental questions about how medical services should be provided. Advocates of such measures as HMOs, cost-sharing strategies, and consumer choice among health plans insist that *something* has to be done to keep the costs of health care from soaring still higher. Convinced that fee-for-service medicine subsidized by private health insurance and by Medicare and Medicaid has provided a blank check to doctors and hospitals, they feel that the system urgently needs to be overhauled. The best hope for making medical care once again an "economic good," in their view, is to make sure that consumers have an incentive to keep costs down and to shop around. Even such established organizations as the American Medical Association and the House of Delegates of the American Hospital Association have endorsed the "consumer choice" concept — as long as it does not result in the rationing of care or a reduction in the quality of medical service.

But many people have fundamental reservations about trying to keep costs of health care down through "pro-competitive" measures. In their view, it is misleading and inappropriate to compare the purchase of medical care with the purchase of a car. They argue that the marketplace is a cold arena for people who are sick and vulnerable, unable to make the calculations that the market demands. From their perspective, health care is not a realm in which economizing is appropriate. If people delay medical diagnoses, or put off needed medical interventions, what appears in the short run to be a prudent way of keeping costs down may turn out to be a very foolish form of economizing.

So one of the debates about health care is between those who would rely on market forces to keep costs down and those who feel that while the market works well for a lot of other purposes, it is not appropriate here. After all, we rely on the public sector to provide certain services — such as police and fire protection — that are essential to our well-being. And we rely on the government particularly when a basic right is at stake. Since access to quality health care is widely regarded as a right that should be denied to no one, perhaps the most promising direction for reform lies not in increased competition but in redefining the government's role. So that is what we turn to next, the government's role in health care — what it is, and what it should be.

3

The Government's Role: Redefining Benefits, Regulating Prices

> **"Although ours is a private health care system, the government plays a major role in it. Many people are convinced that costs could be contained if the government's role were redefined."**

Although people normally think of America's health care system as a private enterprise, the government's role in it is actually quite extensive, and that was true even before the adoption in 1965 of Medicare and Medicaid. On the state and local as well as the federal level, the government has been involved for years in health care. As the operator of a nationwide network of hospitals that expanded rapidly following the Second World War, the Veteran's Administration has been a very visible factor in the health care system. Less visible but hardly less influential were some of the measures adopted in the late 1940s, such as the Hill-Burton Act, which put the power of public finance behind the construction of new hospitals. In dozens of other ways, including state-run hospitals and community health clinics, the government has been an active partner in the health care system for decades.

The Regulatory Approach

Partly because the government's role in health care is so extensive, many people are convinced that decisive government action is necessary if soaring costs are to be contained. The most direct way in which the government can influence costs in this area is to regulate the prices that health care providers charge, which represents a very different strategy for cost reduction from the one proposed by those who advocate a more competitive system.

Those who favor the regulatory approach to cost containment believe that, as much as we might like the health care market to resemble the market for other commodities, it is fundamentally different. In their view, it is unrealistic to assume that in this market providers will ever compete among them-

Photo by Jack Margolin, Courtesy of Gray Panthers

selves to the point where prices are contained by that means alone. Advocates of price control argue that doctors and hospitals are in roughly the same position that fire fighters or policemen would be in if we had to pay for their services. The service they perform is so valuable that when we need it we're in no position to argue about the price. And since the market cannot effectively regulate what health care providers charge, the government has to.

So perhaps the most useful thing the government could do would be to impose limits on how much doctors and hospitals get paid for their services. This is quite a popular approach because it seems to offer a painless solution — a way to contain costs without cutting back services. But this approach is neither so simple nor so trouble-free as it appears. In the 1970s, Congress made several attempts to control rapidly rising hospital expenditures. For example, it created a certificate-of-need program, which required states and localities to approve proposals for new health facilities and equipment. During the Nixon administration, at a time when wage-and-price controls were in effect in many sectors, special limits were placed on the medical profession.

Once controls were lifted, however, prices rose quite rapidly. Several years later, the Carter administration asked Congress for the authority to impose limits on hospital expenditures, the purchase of medical equipment, and the construction of new health facilities. After heated debate, Congress rejected those proposals. As much as the members of Congress wanted to keep costs down, many had reservations about the regulatory approach and whether it is desirable for the government to regulate prices in *any* sector of the economy. Nonetheless, Congress took the regulatory approach in October 1983 when it initiated a new system of reimbursing hospitals that treat Medicare patients. According to that reimbursement procedure, all hospitals are paid the same amount for treating patients whose diagnoses are the same. Some suspect that this new system creates a perverse incentive for hospitals to skimp on care in order to maximize their revenues. Critics are fearful too that when a hospital's costs exceed Medicare's standard reimbursement, the extra costs may be shifted to other patients whose medical bill is not subsidized by the government.

That new reimbursement scheme was put into effect so recently that it is hard to say at this point what its long-term impact will be. Once again, as in the 1970s, what is at issue is whether efforts to do so are likely to be successful.

Re-examining Medicare and Medicaid

There is a second way in which the government could control health care costs, and that is by making substantial changes in the two largest public health care plans, Medicare and Medicaid. Passed by Congress in the heady days of the Great Society, these twin programs were intended to provide health care to individuals who are not covered by private insurance plans. They were intended as a response, in President Johnson's words, "to the injustice which denies the miracle of healing to the old and the poor."

Medicare was intended as a guarantee to the elderly — who use the health care system more than any other segment of the population except newborn babies — that in case of illness they would not be reduced to poverty, or forced to seek a bed in some hospital's charity ward. Medicare represented an extension of the Social Security system. It is a program to which workers and their employers jointly contribute in order to provide health insurance in old age. Medicare was, in brief, an affirmation of the principle that the elderly are both needy and deserving, that they should be entitled to quality health care.

Medicaid — a hastily written, little-discussed program that was passed soon after — represented a joint commitment on the part of the federal government and the states to provide health care to the poor. Together, these two programs held out the promise of equal access to medical care.

When those programs were passed, health care was still often rationed according to people's ability to pay. In 1964, for example, the poor went to physicians 20 percent less often than did the rest of the American population. Whites saw physicians 42 percent more often than did blacks, and individuals from families with incomes under $2,000 per year underwent surgery only half as often as people in families whose income was at least $7,500 per year.

Because of Medicare and Medicaid, which now provide health care coverage for more than 50 million people — about one in five Americans — some of those blatant inequities have been eradicated. Recent studies suggest that while whites still visit physicians more often than blacks, the differences are not so striking as they were two decades ago. Overall, the poor now visit physicians *more* often than the rest of the population, and the rate at which they undergo surgery is substantially higher than for the American population as a whole.

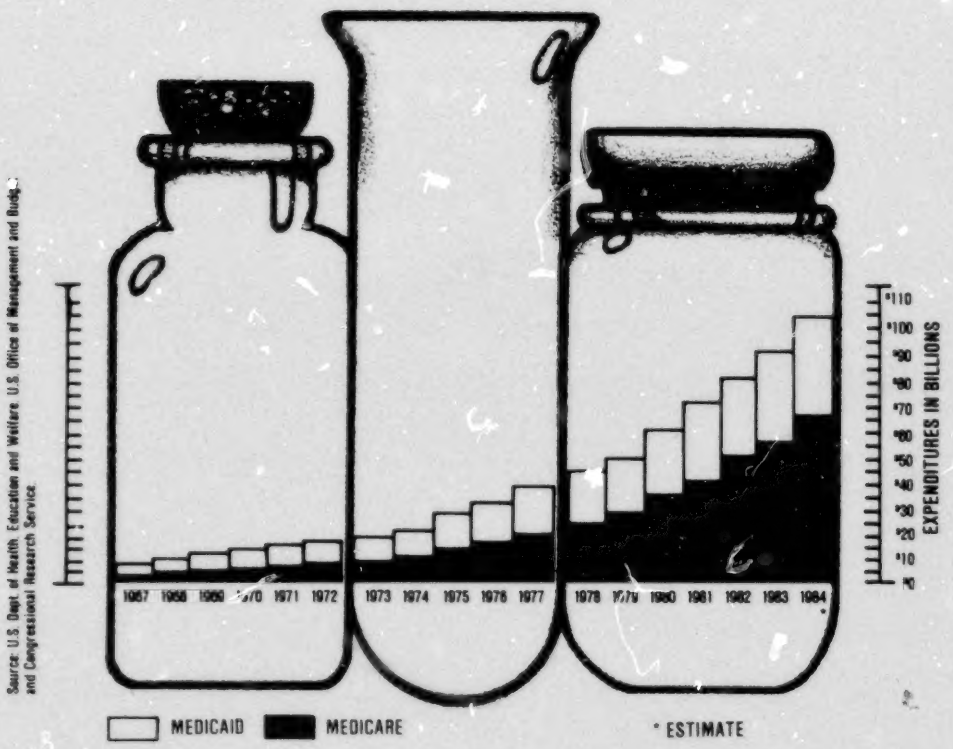
Great Expectations, High Costs

Largely as a result of Medicare and Medicaid, progress has been made toward a society in which people receive quality medical care regardless of their economic means. But those gains have come at a very high cost, far higher than anticipated by the members of Congress who first proposed these programs.

When Medicaid was first proposed, its proponents were convinced that its cost would remain quite modest. Sponsors confidently predicted that it would not exceed $1 billion a year for the forseeable future. In fact, annual expenditures now exceed $30 billion — ten times more than the program cost in its first year. In terms of grants-in-aid to state governments, Medicaid is now the most expensive of all such federal programs.

In targeting public funds for health care for the poor, the

Medicaid and Medicare: Steadily Rising Bills



government identified a real problem but underestimated its severity. The poor are more susceptible to medical problems because of poor nutrition. Because relatively few people from low-income families have routine medical examinations, when they come for treatment their problems tend to be quite serious. Moreover, because they often don't have family physicians, when the poor seek medical attention they frequently resort to the most expensive kind of care, such as that provided by emergency wards. To complicate the matter, the Medicaid program has been plagued with scandal and accusations that both doctors and hospitals are taking advantage of it.

All of these factors have contributed to staggering cost increases for the Medicaid program — increases that averaged 15 percent per year in the late 1970s. That alone created quite a strain on state budgets. The problem got worse in 1981 when for the first time in the history of the Medicaid program, the federal government took steps to reduce its expenditures in this area. Since 1982, federal matching payments for Medicaid have been reduced by at least 3 percent per year. Largely because of the rising costs of providing medical assistance to the indigent, states are faced with a hard choice between raising taxes or paring down the list of people who are eligible for Medicaid.

The story of the Medicare program is much the same. In 1967, the first full year of the Medicare program, expenditures totaled slightly more than $4.5 billion. Within a few years, Medicare became the fastest growing expenditure in the federal budget. Its cost has more than doubled in each five-year period since then. The rate of increase for Medicare currently exceeds every other federal expenditure, including defense spending. Medicare costs for fiscal year 1984 are now estimated at more than $66 billion.

Why are costs of the Medicare program rising so fast? One reason why outlays have increased is that the population is getting older. But the largest influence pushing up the program's expense is simply the accelerating per-patient medical costs. While Congress has already made several attempts to keep the program costs from soaring still higher, these changes are insignificant compared to a projected Medicare deficit of $200 billion in another decade. Medicare's trustees now report that its hospital insurance trust fund will be bankrupt by 1990 unless something is done either to pump more funds into the program or to cut back expenditures.

So, two decades after the passage of Medicare and Medicaid, there is an urgent need to devise some way to contain these programs whose annual cost is about $100 billion and rising.

In June 1984, members of the House and Senate met to discuss a series of new steps to contain the costs of government-subsidized health programs. Those negotiations were widely viewed as a prelude to substantial revisions that must be made

Medicare and Medicaid in Brief: A Guide to Programs and Benefits

What Is Medicare?

Medicare is a federal health insurance program, established in 1965, that covers 27 million aged and about 3 million disabled individuals. Enrollment in Medicare's Part A, the Hospital Insurance Program, is mandatory. Enrollment in Part B, its Supplementary Medical Insurance program, is voluntary.

How Is it Funded?

Medicare is funded by the federal government through the Medicare trust fund, which taxpayers support with a portion of their Social Security tax. In 1984, workers and employers are each required to pay 1.3 per cent of the first $37,800 of an employee's earnings to cover the hospital insurance tax.

Who Are the Beneficiaries?

All persons 65 and over are eligible for benefits. In addition, Medicare provides disability payments to the blind and severely disabled and to those requiring kidney dialysis regardless of their age.

What Does Medicare Cover?

Medicare's Part A pays for hospital care and some home health services. Under certain circumstances, it also pays part of the physician's fees. In addition, it covers 100 days of medically necessary care in a nursing facility. Part B pays for health services and supplies not covered by hospital insurance, including physician's fees, diagnostic tests, therapy, and the costs of surgery.

How Much Does the Recipient Pay?

Medicare's Part A has several cost-sharing provisions. One is a deductible of $356 — roughly equivalent to the cost of one day in the hospital — for the first 60 days of care. Another is a co-payment of $89 per day for the 61st through the 90th days of a hospital stay. For the next two months of a hospital stay, there is a daily co-payment of $178. Similarly, there are two ways in which people enrolled in the Supplementary Medical Insurance program (Part B) share expenses. They pay a monthly premium of $17.70. They also pay the first $75 of covered expenses as a deductible.

For Further Information

To apply for Medicare benefits, visit your local Social Security Administration office. For more detailed information, ask for a copy of *Your Medicare Handbook*.

What Is Medicaid?

Medicaid is a program that provides medical assistance for low-income persons who are blind, disabled, or members of families with dependent children. At a cost of about $30 billion in 1983, it provided benefits to 23 million people.

How Is it Funded?

Medicaid is funded jointly by the federal government and the states. The federal share of Medicaid expenditures varies from one state to another depending upon the average income of residents in the state. Nationwide, slightly more than half of the program's costs are paid out of federal tax dollars, the rest from state funds.

Who Are the Beneficiaries?

Eligibility standards vary from state to state. Medicaid covers those persons who receive payments under Aid to Families with Dependent Children and Supplementary Security Income (for the aged, blind, and disabled). Others are eligible in some states depending upon their income, their assets, and the extent of their medical expenses. Nationwide, about a third of Medicaid benefits are paid to hospitals providing services to poor children and their mothers. The largest portion of Medicaid funds is paid for medical services provided to women over 50 who are widowed or divorced.

What Does Medicaid Cover?

Medical services covered by Medicaid vary widely from state to state. However, all states are required to cover certain costs such as laboratory and X-ray services, physician services, hospital services, and certain types of nursing care to patients who qualify. More than four out of ten Medicaid dollars are paid to nursing homes for some nine million elderly and disabled recipients.

How Much Does the Recipient Pay?

Under present Medicaid law, states are permitted to require co-payments of Medicaid recipients. Most states, however, do not require any form of payment for visits to doctors or hospitals. The majority of states that have decided to charge certain co-payments have generally done so only for the costs of prescription drugs.

For Further Information

To find out more about Medicaid programs, contact either your state Department of Health or the State Welfare Department.

to keep Medicare's hospital insurance fund from becoming insolvent by 1990. Similar discussions are taking place in state capitals about the future of Medicaid. The proposals under discussion raise some basic questions about what the government's role should be in health care, who should benefit, and how much of the cost of medical help individuals should bear. Let us examine four proposals, the extent to which they might offer a solution to the problem of soaring costs, and what they would mean for beneficiaries and taxpayers.

The Cost-Sharing Approach

While Congress has been trying to contain the costs of publicly subsidized health care programs by taking the politically popular approach of imposing limits on what providers can charge, it has also been moving toward an unpopular but potentially effective remedy — charging the people who are covered by Medicare and Medicaid more for the medical services they receive. As already noted, many students of the private insurance system argue that the best way to control costs is to ask patients to bear some of the first-dollar costs of hospitalization and health care as a reminder of the cost of the services they receive. The same argument is made about publicly subsidized health care. Many people are convinced that the chief reason why the cost of the Medicare and Medicaid programs has escalated so rapidly is that recipients don't have much of an incentive to economize. In their view, public subsidies for the health care of some 50 million Americans have encouraged recipients to act as if it were a free good. What is needed, they feel, are additional cost-sharing measures that would deter unnecessary or excessive use.

That is what the administration had in mind recently when it proposed that beneficiaries of the Medicaid program should be required to pay the nominal fee of a dollar or two for each visit to a physician and for each day of hospital care. Currently, although states are permitted to impose modest cost sharing on most Medicaid recipients, most states do not require beneficiaries to pay anything for visits to doctors or hospitals. In the states that do require patients to pay for part of what they receive, co-payments are required only for the cost of prescription drugs.

When spokesmen for the administration made the case for mandatory co-payments for all Medicaid recipients, they argued that savings would be substantial not because of the modest amounts recipients would pay, but because those out-of-pocket fees would serve as a reminder not to use medical facilities unnecessarily. But is this strategy for containing health care costs likely to work? Evidence indicates that it will. Several years ago, in an experiment conducted in California, the state imposed a small charge on some of the state's Medicaid recipients. People who previously received free care were required to pay one dollar for their first two office visits each month and 50 cents for their first two prescriptions in a month. The study

Charles Harbutt/Archive

In addition to the medical services for the elderly provided by Medicare, a large portion of the Medicaid program pays for the health bills and nursing care of the elderly — particularly older women who are widowed or divorced.

"Congress has been moving toward an unpopular but potentially effective remedy—charging the people who are covered by Medicare and Medicaid more for the medical services they receive."

Courtesy United Steelworkers of America

While some of the administration's proposals have been criticized as insensitive to the needs of the poor and the elderly, the proposals respond to a real need: to keep the costs of publicly subsidized health care programs from soaring still higher.

showed that even the charge of a dollar reduced office visits to doctors by about ten percent. It appears that when people can no longer count on first-dollar coverage, they think twice about using medical services.

But when the administration recently proposed mandatory co-payments for Medicaid recipients, Congress rejected the proposal. Critics of the administration's proposal were concerned that imposing *any* additional costs on the poor people who are served by this program would represent a financial burden, particularly for the chronically ill who make frequent visits to doctors or hospitals. So, for the time being at least, most Medicaid recipients are not required to pay for any portion of the medical services they receive.

Unlike the Medicaid program, Medicare has required beneficiaries to pay part of the cost of their care since it was first put into effect. Medicare's hospital insurance plan has several cost-sharing provisions. One of them is a deductible equal to the average cost of one day in the hospital. (In 1984, the amount of that deductible is $356.) Another is a co-payment of $89 per day for hospital stays longer than 60 days. Similarly, individuals enrolled in Medicare's Supplementary Medical Insurance program (Part B) share expenses in two ways. They pay for monthly premiums (at a cost of $17.76 per month in 1984), and must pay for the first $75 of covered expenses as a deductible.

Here, too, as with the Medicaid program, the administration has proposed that beneficiaries should pay more of the cost of care out of their own pockets. One proposal would impose additional costs for a hospital stay — increasing the cost of a typical 11-day stay from its current level of $356 (the deductible) to about $600. Arguing that premiums for Medicare Part B coverage have not kept pace with rising costs, the administration would also raise the monthly premium by 40 percent over the next five years.

If such additional cost-sharing measures were approved, their cost would still be paid by the "medigap" insurance that many older people buy to pay for the expenses that Medicare doesn't cover. But the cost of that insurance would increase proportionately. So, directly or indirectly, the burden of cost sharing would be borne by the elderly.

Should the elderly be asked to pay more out of pocket for medical expenses? Some people feel that it is entirely appropriate to ask retired people who can afford to pay for more of the medical expenses to do so. As Richard Rahn, an economist with the U.S. Chamber of Commerce, points out, most of the elderly are not poor. In fact, the average income of elderly couples in this country is now about $14,000, just $5,000 less than the average household income for all families. Rahn feels that the basic issue is one of intergenerational equity. "Most older people can afford $100 or $200, or even $1,000 for their own medical care," he says. That is a fairer solution, he feels, than asking people who are currently in the work force to shoulder the entire burden of Medicare's growing cost.

But groups representing the elderly strenuously disagree. They point out that individuals 65 and over are already paying a lot for their health care. While Medicare pays for most of the costs of hospital care, it pays less than half of the doctor's bills. In addition, the elderly have to pay for dental care, eyeglasses, prescription drugs, and hearing aids. In all, elderly people devote about 15 percent of their income to health care. Critics of cost sharing are particularly concerned about elderly people with only limited means. For people at or near the poverty line of $5,000, any increase in the amount they have to pay would force them into the Medicaid program, thus offsetting the savings to the government that were intended in the first place. Opponents of cost sharing such as Senator Edward Kennedy feel that older people should not have to choose "between food on their table, heat for their home, or an appointment with their doctor."

A modification that might be made to protect those with modest incomes would be to turn Medicare into a means-tested program. In other words, it might be refashioned into a program that continues to offer benefits to everyone, while demanding higher deductibles and co-payments only of those whose income is above a certain level. What is at issue here is whether the government ought to subsidize those who are better off to the same extent that it subsidizes the poor. Some people feel that the same rules ought to apply to all Medicare recipients, since all workers pay into the program through payroll deductions. Others think that it makes sense to ask those who are able to pay more to do so.

Regardless of whether a means test is used to determine how much recipients should pay, cost sharing remains a controversial approach to the problems facing these publicly sub-

sidized programs. To its proponents, it is a sensible solution to a serious problem. Its critics agree that the problem is serious — but conclude that we should look elsewhere for a solution.

The Cost of Catastrophic Illness

Looking in a different direction for some way to keep the costs of the Medicare program from soaring higher, the administration has proposed an alternative solution. The program's costs could be substantially pared down by changing the nature of the coverage offered, and emphasizing coverage for catastrophic illness. While Medicare currently pays most of the cost of the first 60 days of hospital care, it pays less for every day thereafter. If an elderly person has the misfortune of a severe illness that requires a long hospital stay, the expense can eat up the family's savings and lead to the poverty that Medicare was supposed to prevent. That possibility, some critics contend, is a basic flaw in the program: its payment scheme is backwards, creating the greatest hardship for those who are most seriously ill and in need of care.

The administration has proposed to correct that flaw by changing Medicare benefits so that they provide protection against catastrophic illness, while paying less of the costs of short-term hospital care. The effect would be to cut Medicare's overall costs. What the administration proposed was to charge people more for the first 60 days of a hospital stay, but to guarantee coverage of all hospital expenses after that. The people who would benefit from catastrophic coverage are the seriously ill who require prolonged hospital care. Since relatively few people require such prolonged care, the cost of their care would be more than offset by additional charges to patients for the first 60 days.

But many object to this proposal on the ground that, even more than the plans which impose higher deductibles, this would create an additional burden for elderly people who simply cannot afford to pay more for their medical care. Advocates of the proposal reply that it would provide something that the current plan does not, the peace of mind of having unlimited protection. With catastrophic coverage, while the elderly would have to pay more for medical care initially, they wouldn't have to worry about losing their homes or becoming indigent in the event of prolonged illness.

So this plan would substantially redefine Medicare and guarantee benefits to the few who are currently in greatest jeopardy. It would make Medicare coverage more like the insurance you buy for your automobile or for fire protection. Most people would not receive many benefits from it, but the benefits that some people receive would keep them from financial ruin.

The debate over shifting to a Medicare system that provides catastrophic coverage comes down to this basic issue: which risks should individuals bear themselves? Which, be-

National Health Insurance

Most of the debate about government-sponsored health care programs now focuses on cost containment. However, some people take a different approach. They insist that the first problem we should address isn't the high cost of such programs as Medicare and Medicaid but the fact that many Americans are still without *any* health insurance. From their perspective, existing government programs don't go far enough. What the nation needs, they believe, is a health insurance system that guarantees medical care for everyone.

That is an idea that President Harry Truman first proposed. "The benefits of medical science have not been enjoyed by our citizens with any degree of equality," said Truman in 1945, "nor will they be in the future — unless government is bold enough to do something about it." Medicare and Medicaid represent two attempts to do something about it. Because of those programs the current system provides for many Americans who were not covered a generation ago. But advocates of national health insurance are concerned that 23 million Americans — about 10 percent of the population — still lack health care coverage.

The people who lose out are those who don't fit into Medicaid's eligibility categories, an estimated 12 million people with income below the poverty level who nonetheless are ineligible for Medicaid. In addition, there are many working poor who earn too much to qualify for public assistance but too little to afford private insurance. These are people who are self-employed or who work at part-time jobs — as waitresses, sales clerks, or domestic workers for example — that do not provide health benefits. A third category of people who are not covered are those temporarily out of work. Not poor enough to qualify for Medicaid, but without a steady income to pay for private insurance, they suffer the double jeopardy of economic insecurity as well as fears about how to cope if they need medical assistance.

Several plans to broaden access to health care have been submitted to the 98th Congress. While there are substantial differences among them in how a system of national health insurance would be financed and what the system would cover, those proposals reflect a common concern for making health care coverage available to *all* Americans.

While their advocates acknowledge that virtually any national health insurance plan would cost more than the existing system, they insist that we should not refrain from doing what is right in the name of economy and efficiency. They believe that at a time when one out of every ten Americans lacks health insurance, our first concern should be to extend to those people the coverage that everyone else enjoys — and *then* figure out how to pay for it.

cause they are simply too costly and devastating, should be shared and paid for collectively?

Choosing Health Care Providers

A third proposed reform poses quite a different issue. It forces us to consider whether recipients of Medicaid should be free to go to any doctor or hospital they choose. Currently, Medicaid recipients may obtain health services from any practitioner or provider willing to render medical services. The people who designed the Medicaid program were fearful that if recipients were restricted to just a few designated providers, the health care system would soon have two distinct tiers — it would provide quality care for most people and second-rate service for the poor.

But in giving Medicaid recipients the freedom to go to the doctor or hospital of their choice, existing regulations also give them the freedom to choose some very costly forms of care. And that is what concerns the people who advocate this third proposal for cost cutting. They point out that since Medicaid recipients have no incentive to think twice about where they go when they need medical assistance, they often choose the most expensive care available. Rather than going regularly to the same doctor, many Medicaid recipients go to different hospitals and doctors on different occasions — and each time they repeat a costly series of diagnostic tests. Lacking any incentive to go to health care providers with a record of keeping costs down, such as HMOs, Medicaid recipients often choose the most expensive alternative, hospital emergency rooms, even if they require only routine medical assistance. That, critics contend, is one of the chief reasons why Medicaid's costs are now so much higher than they were when the program started. From their point of view, it simply doesn't make sense to have a health care system in which people whose health care is publicly subsidized have fewer incentives to economize than everyone else.

"If none of the alternative methods of paring down the costs of Medicare and Medicaid is acceptable, that leaves us with some hard choices about how to raise the funds needed to pay for them."

What, then, might be done? States might insist that Medicaid recipients go only to certain specified doctors or hospitals whose rates are reasonably low, or to health care providers such as HMOs that have a record of keeping costs down.

Like the other reform proposals, this one provokes very different reactions. Some people feel that all patients should be free to choose their own health care providers, and that designated providers for Medicaid patients are very likely to provide second-rate service. Others feel that, especially at a time when people are being dropped from the Medicaid rolls because costs have become so burdensome, it is not unreasonable to ask the people who receive public funds to go to providers who charge somewhat less for their services.

Paying for What We Want

But perhaps none of these cost-cutting alternatives is accept-

The Bettmann Archive

One of the benefits that Medicare provides is that it covers the cost of surgery for many elderly Americans.

able. Some people regard the Medicare and Medicaid programs as promises that must be met. When these programs were passed by Congress in the 1960s, they represented a commitment to provide quality health care to most Americans, regardless of their economic means. To defenders of the Medicare system, any plan that would either shift medical costs back to the beneficiaries or reduce benefits is unacceptable. Their view is that Medicare — like Social Security — represents a compact between the generations and one that embodies heartfelt values about what we owe not only to the elderly, but also to others who are unable to provide for themselves. Proponents of this position think that since millions of retired Americans made their financial plans assuming the current level of benefits, it would be unconscionable to change this level with so little notice.

However, if none of the alternative methods of paring down the cost of Medicare and Medicaid is acceptable, that leaves us with some hard choices about how to raise the funds that are needed to pay for them. We might, of course, agree to higher state and federal taxes to cover the escalating cost of Medicaid. But that is something that many taxpayers firmly oppose. To solve Medicare's fiscal crisis, we might agree to higher payroll deductions. Currently, employers and employees are each paying 1.3 percent of earnings into the hospital trust fund. The Congressional Budget Office estimates that if payroll taxes were used as the sole method of restoring the solvency of Medicare's hospital trust fund, payroll deductions would have to be about twice as high as that by 1995, and then increase steadily thereafter. If that is the way we choose to resolve this problem, both employees and employers will have to pay, within a few years, almost ten percent of the employee's wages for Medicare and Social Security.

The question is how much further we are willing to go in the direction of taxing people who are currently in the work force to pay for those who are retired. At a time when programs for the elderly constitute the most costly item on the federal budget, some people conclude that we have reached the limit of what can be committed for the aged.

For all the technical detail in some of these proposals, the discussion of reforming Medicare and Medicaid comes down to matters of fairness and compassion, and reaching a balance between what we have promised and what we can afford. If the cost of Medicare and Medicaid cannot be pared down, we will have to figure out the fairest way to distribute their increasing cost.

No matter how we deal with these publicly subsidized programs, however, the cost of medical care for the elderly is likely to continue to rise because of technological advances that are keeping people alive longer. So we turn now to a third set of choices about medical care, choices that are posed by new medical technologies.

The High Cost of Heroic Measures

"New diagnostic and surgical techniques allow doctors to do far more than they formerly could. But are their high costs justified by the results?"

Early in December 1982, two names were prominent in the news — Barney Clark and Jarvik 7. Barney Clark, the Seattle dentist who became the first human recipient of an artificial heart, received most of the attention. The person who made that operation possible was physician Robert K. Jarvik, who invented the artificial heart and for whom the operation represented the successful outcome of ten years of research. The fist-sized plastic and metal device that afforded Barney Clark an extra 112 days of life was another impressive demonstration of state-of-the-art medical technology that has revolutionized the treatment of heart patients over the past decade.

Even in the midst of the celebration of that medical breakthrough, however, two very practical questions were being raised: once it is possible to implant artificial hearts routinely, who should be permitted to have them? And who will pay for them? The cost will be high. Estimates are that even after the procedure is perfected, an artificial heart will cost at least $50,000 and post-surgical care may cost as much as $100,000. Since some 50,000 Americans could be considered suitable candidates for a heart implantation, the annual bill might come to $4 billion.

The artificial heart is only the most recent in a series of medical advances. Time after time, we have seen that what is experimental today redefines the accepted standard of medical practice tommorrow, and that the cost of these new medical procedures is stunningly high. Consider, for example, the most significant advance in open-heart surgery over the past two decades, the coronary-bypass operation. Regarded as an experimental operation as recently as the early 1970s, this is now a $3 billion-a-year industry. Some 165,000 Americans now have bypass surgery each year, at an average cost of more than $20,000.

Consider the history of another procedure that has saved the lives of thousands of people — kidney dialysis. Before 1975, only 6,000 people in the United States used dialysis machines. Then Medicare took over dialysis payments. Today, more than 60,000 people use dialysis machines, at an annual cost exceeding $1 billion.

Those are only two items from a substantial list of recent medical breakthroughs. Sophisticated instruments and procedures such as the CT scanner (computerized X-ray equipment that produces a cross-sectional picture of a patient's body), hip replacements, and kidney transplant operations are some of the other advances of the past decade. Additional procedures are waiting in the wings, including the artificial lung and the artificial pancreas, artificial skin for the treatment of burns, and electronic implants that may restore hearing to the deaf and sight to the blind.

Every year brings a remarkable advance in medical technology. And because the money is available in the United States to use new medical technologies, they come into general use faster in this country. Costs have gone up because physicians

feel obliged to do everything that medical science and technology *can* do — and that's a lot more, and a lot more expensive than it used to be.

Why Don't Doctors Control Costs?

There is no question that health care costs could be reduced if physicians routinely prescribed fewer diagnostic tests, if they confined "heroic" measures to those who clearly would derive the most benefit from them, and if hospitals refrained from buying expensive new equipment that benefits relatively few patients.

Why then don't hospitals and physicians cut back on expensive medical services to keep costs down? The most direct answer is that the ethical imperative of the medical profession is not to keep costs down but to do everything possible for the patient. After all, an additional test or treatment *might* help.

But there are other reasons why physicians order more tests than may be necessary, or pursue the aggressive treatment of terminally ill patients.

While physicians recognize that such treatment may be pointless, that it may amount to nothing more than a very painful and expensive prolongation of life, they nonetheless feel that they cannot do anything less because of pressure from the patient's family and because of the threat of malpractice suits. Many physicians have taken to practicing what is known as defensive medicine — prescribing tests, or keeping terminally ill patients connected to life-sustaining equipment so that if they are sued, they can show that they exercised every possible precaution. The great majority of malpractice suits against doctors are ultimately dropped or dismissed because they have no valid legal basis. But that is no deterrent to an increasing number of people who question the judgment of medical professionals, and seek damages for an unsuccessful medical outcome.

This threat also leads to more expensive malpractice insurance, especially for physicians who practice high-risk procedures such as open-heart surgery — yet another cost of doing business for both doctors and hospitals.

There is a third reason why most doctors do everything they can do for patients regardless of cost or the prospects of success, and this takes us to the heart of the matter. There are no clearly defined criteria for rationing care. If we want doctors to be cost savers for society as well as advocates and healers of the ill, we are at the very least imposing contradictory requirements on them. If firm budget limits were placed on hospital care, someone would have to make the decisions about who would receive care and who would not. Such choices are routinely made on the battlefield. Physicians in the military have long understood that when there are too few resources to take care of all of the wounded, decisions have to be made about which patients stand to benefit the most from treatment, which means denying treatment to some. Is this a power that we want to give to doctors? "Not to push with all available resources in

Brad Nelson, University of Utah Medical Center

Barney Clark was the recipient of the first human artificial heart transplant, in an operation performed by surgeon William DeVries in 1982.

"Time after time, we have seen that what is experimental today redefines the accepted standard of medical practice tomorrow, and that the cost of new medical procedures is stunningly high."

Ann Chwatsky

Sophisticated intensive care units such as this one give lifesaving support to infants born prematurely.

every case leaves us open to accusation of presuming godlike powers in deciding who shall live and who shall die," writes Dr. Alexander Leaf, chairman of Harvard's department of preventive medicine. "On the other hand, to push with all available resources when the probability of improvement seems vanishingly small leaves us open to the accusation of presuming godlike powers of healing." To balance such demands, to ration medical care — that is the bitter issue raised by the proliferation of high-cost medical technologies.

Guidelines for Rationing Care

Medical groups have been understandably reluctant to address the sensitive problem of rationing. In June 1984, at the annual meeting of the American Medical Association in Chicago, one of the chief topics was what physicians could do to control medical costs. There was a good deal of discussion about rationing care, which has become an emotional issue because of the refusal of some Medicaid agencies and insurance groups to pay for extremely expensive procedures such as organ transplants. But the delegates finally supported the position of the AMA's board of trustees, that it would be inappropriate "for the association, by itself, to develop guidelines for the rationing of care."

If the AMA has been reluctant to take a position on the question of rationing medical care, both insurance companies and the federal government have been forced to grapple with it. With the success rate in organ transplants rising, it has become a pressing matter to decide whether unlimited insurance funds should be made available for each new medical treatment. Heart transplants, which cost between $75,000 and $125,000, forced the issue. Today, about 50 heart transplants are done every year, but far more people could benefit from them. Medicare still considers heart transplants — like liver and pancreas transplants — experimental, and does not currently pay for the surgery, but that could change. As former Secretary of Health and Human Services Patricia Harris put it, a significant increase in the number of persons undergoing heart transplant raises "many unanswered questions" about such matters as the patient selection process and the long-term social, economic, and ethical consequences of the procedure.

It also raises the question of whether we may be unable to respond to *other* medical problems if we devote substantial funds to organ transplants. Cost-conscious experts at the Department of Health and Human Services point out, for example, that if only 2,000 heart transplants took place each year — a conservative estimate — that would cost the Medicare program at least $500 million dollars. That sum is far more then the cost of a proposed child health assurance program which would benefit several million children. Is there a way to balance the needs of 2,000 people who need heart transplants and several million low-income children and pregnant women who would benefit from that proposed health assurance program?

The heart transplant issue forces us to ask whether there are limits to the health care that any society can afford, particularly for procedures that benefit relatively few people. Recently, the trustees of the Massachusetts General Hospital in Boston raised these questions in deliberations on whether they should start a heart transplant program. Essentially, they weighed the value of saving six lives per year against the economic impact of that program on all of the other patients at Massachusetts General, and its effect on the incidence of cardiovascular death in the entire society. Concluding that they have a responsibility to evaluate new procedures on the basis of their contribution to the greatest good for the greatest number, the trustees decided against a heart transplant program.

Similar questions were raised this past spring when Blue Cross and Blue Shield announced guidelines intended to contain health care costs by reducing lab tests and radiological procedures. Few people question the value of sophisticated new diagnostic equipment that provides far better information than was available a generation ago when doctors depended upon little more than their own intuition and the tools in their black bag. Technological advances in diagnostic equipment deserve much of the credit for the success of modern medicine.

Nonetheless, Blue Cross and Blue Shield, with their "medical necessity guidelines," are trying to reduce the unnecessary tests that they feel substantially increase medical costs for some 80 million subscribers. A common diagnostic practice,

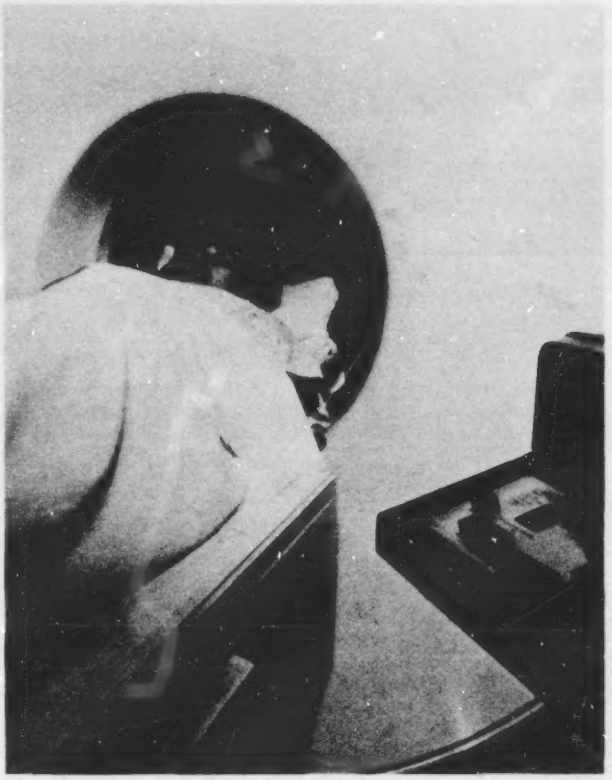
for example, is the routine use of X rays in hospital admissions, whether or not they are very likely to provide additional information to the attending physician. Blue Cross recommends that such X rays not be done routinely. Another example of what Blue Cross regards as an unwarranted use of diagnostic tools is ultrasound equipment, employed in roughly 40 percent of all pregnancies to gauge the condition of the mother and the fetus. Blue Cross considers ultrasound to be a necessary diagnostic tool only when a problem is suspected. In most cases, ultrasound pictures provide no more that a curious addition to baby albums.

How Necessary Are CT Scanners?

One of Blue Cross' main concerns is to prevent unwarranted use of the most sophisticated and costly of diagnostic tools, the CT scanner. The scanner is a convenient, noninvasive instrument that can be used to diagnose a wide variety of disorders. Essentially, it is a computer-assisted X-ray machine capable of producing a cross-sectional picture of any part of the body. Because it is capable of distinguishing between brain tissue and a tumor, for example, and because it pinpoints the location of such abnormalities as tumors and identifies their size, it provides far better information than ordinary X rays do. Considered one of the most significant of recent breakthroughs in medical technology, the CT scanner is a piece of equipment that most hospitals would like to have, despite a price tag of at least a million dollars.

Critics concerned about the tendency of hospitals to purchase complex machinery as a badge of prestige have insisted that CT scanners should not be installed in every hospital. Since 1974, when the federal government began requiring hospitals to obtain a certificate of need from a health planning agency before making major capital expenditures, many hospitals have been denied CT scanners.

The fact that D.C. General Hospital in Washington was one of the hospitals that didn't have a scanner became an issue in April 1981, when Loraine Blake, a Washington schoolteacher, was admitted to the hospital's emergency room complaining of a severe headache. Several hours later she slipped into a coma from which she did not recover. Two weeks later she died. Her husband sued the city, which runs the hospital, for not taking Mrs. Blake to one of the area hospitals equipped with CT scanners. Such scanners are especially important in emergency rooms because they provide a fast and accurate diagnosis of head injuries. The judge didn't find the hospital at fault for not having the equipment. But Mr. Blake won his suit against the city for failing to transfer Mrs. Blake to a hospital equipped with a CT scanner. When journalists followed up the story, it was determined that in a six-month period, eight people died at D.C. General who might have lived if the hospital had been equipped with a CT scanner. There was a good deal of criticism of a procedure which, in the name of containing medical costs, keeps doctors and hospitals from purchasing the equipment they need — and then results in the loss of life. That underlines the basic issue: what value do we place on a human life? What costs are we willing to pay for technologies that save only a few lives per year?

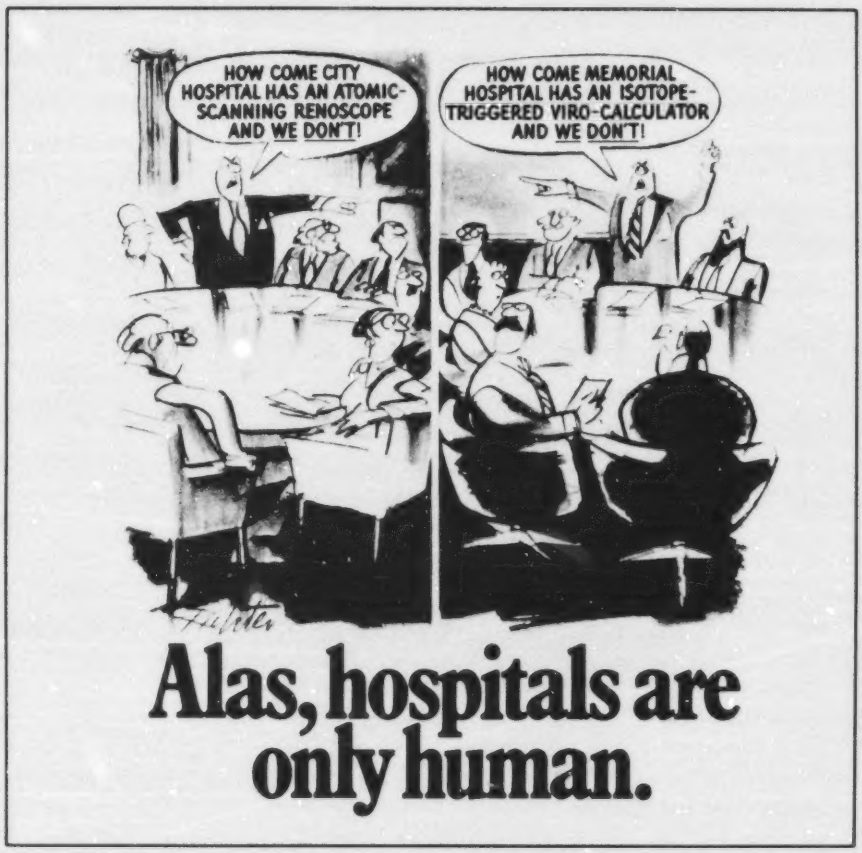


Dan McCoy/Rainbow

Breakthroughs in medical technology provide powerful new diagnostic tools such as the CT scanner.

Even though the certificate-of-need procedure has kept many hospitals from purchasing CT scanners, they are becoming increasingly common. It is estimated that there are now some 3,000 of them nationwide. Because their initial cost is so high, they have to be run at high volume to keep average costs down. For that reason, there is a strong incentive to use them — as the Blue Cross guidelines point out — even when patients complain of nothing more than minor headaches, at a cost of more than $300 to the patient (or the insurer).

It seems clear that in many cases where CT scanners are used, the additional information they provide is not worth the cost. But how relevant is this consideration? Should all hospitals have equipment like CT scanners, regardless of their expense, in order to prevent the death of people like Loraine Blake? Or should hospitals be required to assess such big-ticket purchases with an eye toward cost effectiveness, even if it means that some people will be deprived of the advantages of state-of-the-art equipment?


HOW COME CITY HOSPITAL HAS AN ATOMIC-SCANNING RENOSCOPE AND WE DON'T!
HOW COME MEMORIAL HOSPITAL HAS AN ISOTOPE-TRIGGERED VIRO-CALCULATOR AND WE DON'T!
Alas, hospitals are only human.

Courtesy of AEtna Life and Casualty

Critics charge that many hospitals buy every new piece of equipment that is developed, regardless of its cost, as a badge of institutional prestige.

Intensive Care

Some of the most contentious discussions of health care rationing involve the use of intensive care units, called ICUs. It is in ICUs that a variety of medical technologies — including respirators, antibiotics, and pacemakers — are employed to keep alive people who until recently would have had little chance of surviving. In the words of Colorado's Governor Richard Lamm, "Medical science is replacing God in deciding when we die."

Today, many hospitals are equipped with intensive care units for premature infants. Six percent of all live births in the country involve premature or critically ill babies who require intensive care. At a cost roughly equal to that of coronary-bypass surgery, premature infants weighing as little as two to three pounds often survive to lead normal lives. The question — as with each of these other medical technologies — is whether we're willing to pay roughly $150,000 for the care of an infant who would almost certainly die without such deliberate and intensive treatment. Recognizing that infants weighing less than about two and one-fourth pounds are more likely to be severely handicapped, where should we draw the line between infants who should receive intensive care and those who should not? Carried to the extreme, these heroic measures seem to some people to represent the nightmare of modern medicine gone awry. In one instance a couple described how their baby, who was born with major defects, was kept alive against their wishes — until he died six months and more than $100,000 later.

Decisions regarding the elderly in intensive care are equally wrenching — for the patient, the patient's family, and the physician. It is significant that doctors don't very often speak any more of death by natural causes. The sicknesses that once were the chief causes of death among the elderly, such as pneumonia — which used to be referred to as "the old man's friend," sparing people from years of disability and allowing a relatively speedy and dignified death — can now be arrested through the use of antibiotics, respirators, and other means. Modern medicine allows doctors to sustain life far longer than in the past. To some, they keep withered leaves on the tree long after nature would have let them fall.

Longer life is of course something to be valued. The fact that books on "prolongevity" and extending one's life span are best sellers suggests how eager people are to live longer. What is at issue here is not the measures that might be taken to protect

The Slow, Costly Death of Mrs. K.

At a time when there is increasing debate about the value of intensive care for the terminally ill, David Hellerstein, a New York City physician, examined the hospital bill for one elderly woman, Mrs. K. After 25 days in the hospital, almost all of it in the intensive care unit, there were some 700 items on her bill, whose total amount was $47,311.20. Reconstructing from that bill what happened in Mrs. K's last days, Dr. Hellerstein provides a vivid portrait of what intensive care means.

September 23: Mrs. K. has been taken to the emergency room of a renowned hospital on Manhattan's Upper West Side. More than $200 worth of blood tests are ordered, $232 worth of X rays taken, $97.50 worth of drugs administered. She is sick, very sick.

September 24: Mrs. K. has been moved to the Intensive Care Unit. It costs $500 a day to stay in the ICU, base rate. ICUs were developed in the 1960s. They provide technological life-support systems and allow for extraordinary patient monitoring. Without the attention she is receiving in the ICU, Mrs. K. might already be dead.

September 26: Mrs. K. has been running a high fever. She is put on gentamicin, a powerful antibiotic.

September 27: It is Mrs. K's fifth day at the hospital, and she is slipping closer to death: her lungs begin to fail. She is put on a respirator which costs $119 a day to rent and requires a special technician to operate.

September 29: Mrs. K's first week in intensive care ends in a flourish of blood tests. She has five Chem-8 tests that measure the level of sodium, potassium, and six other chemicals in her blood. The hospital charges Mrs. K. $31 for each Chem-8. Mrs. K. has also started peritoneal dialysis. Her kidneys are failing. She is still hooked up to the respirator. She is being kept alive by what Lewis Thomas calls "halfway" technologies — "halfway" because kidney dialysis machines and respirators can support organ systems for long periods of time, but can't cure the underlying disease.

September 30: Mrs. K. has been put in a vest restraint. Restraints are used in intensive care to keep patients from thrashing about or pulling their tubes out. Many ICU patients develop what is called "ICU psychosis." They become disoriented and begin hallucinating. The condition is brought on by lack of sleep, toxic drugs, the noise of the ICU staff and machines, and pain.

October 6: Mrs. K. has been in intensive care for two weeks. She is still running a very high fever. Mrs. K. has been placed on a special blanket; it is hooked up to a machine that functions like a refrigerator. The blanket helps lower Mrs. K's body temperature. Should her temperature rise too high, she may suffer permanent brain-damage.

October 15: Mrs. K's fourth week in the hospital begins with a spinal tap. Using a long needle, a doctor drains fluid from her spinal cord. A spinal tap is performed when a patient has what are called "neurological signs." Partial paralysis is one such sign, loss of consciousness another. When doctors order a spinal tap, they suspect brain disease.

October 17: Weeks of halfway technology have given the doctors time for testing. The doctors may even have diagnosed what is wrong with Mrs. K. But the ICU and its technology have not given them the ability to cure her. Now the heart, which has been failing, gives out: cardiac arrest. There is a burst of activity. Bicarbonate, epinephrine, and other drugs are administered. Thirteen bottles of intravenous solution are poured in.

October 18: Mrs. K's last minutes are recorded on the various ICU monitors. The level of oxygen in her blood falls. She dies. Total cost of 25 days in the hospital, nearly all this time in intensive care: $47,311.20. Of this, Blue Cross will pay $41,933.87. The doctors' bills that are not covered by hospitalization insurance come to thousands of dollars more. In 1982, the last year for which figures are available, Americans spent $322 billion on health care. Of this, $135.5 billion was spent on hospital care. There were 56,241 ICU beds in 1982 like the one Mrs. K. was kept alive in, and about $27 billion was spent for their use. That represented nearly one percent of the gross national product.

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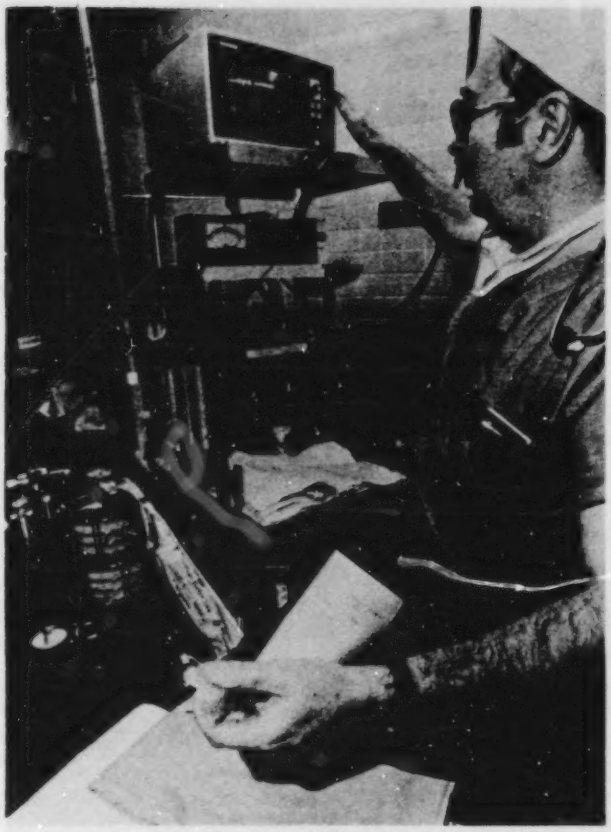


AP Wide World Photos

One example of today's sophisticated medical technologies, the computerized respiratory monitoring system, allows doctors such as Stephen Finestone of Pittsburgh's Montefiore Hospital to accurately monitor patients' vital signs.

an otherwise healthy middle-aged adult from a particular medical peril — thus to allow that individual a normal life span of three score and ten. The question is what, if anything, should be done to extend human life beyond that point for individuals who are aged and infirm? Even in biblical times, the age of 70 was not regarded as an absolute upper limit. The psalmist held out the possibility of 80 years "by reason of strength." But how do we feel about extending life for the elderly for months or years solely through life-sustaining treatment?

This is so sensitive a topic that it is difficult to raise the possibility that we may already have gone too far in the direction of routinely resorting to intensive care for the elderly — care that in many cases only marginally increases risk, but greatly adds to the cost of treatment. Fully 80 percent of Americans die in hospitals or nursing homes, most of them in the course of receiving some sort of medical treatment. Last year, Medicare alone paid about $15 billion for the care of the terminally ill in their last six months of life. Some critics regard that expenditure not as an expression of collective compassion for the elderly but as evidence of our disinclination to develop guidelines for the use of an extraordinarily expensive medical technology. In the words of British observer Norman Macrae, "Although third-party insurance makes it profitable for a doctor to pump the finest medications into an unprotesting near-corpse, there is no evidence that this extended the average patient's life by more than a few harrowing days. For each day that it did, it will have raised the national health bill by nearly another $100 million."

Any such statement provokes the furor of people who regard discussion of the rationing of medical care as a blatant insult to the elderly. In remarks to the Colorado Health Lawyers Association in 1983, Governor Richard Lamm said that "We've got a duty to die, to get out of the way with our machines and our artificial hearts." He was referring to the terminally ill and the importance of facing up to the difficult question of when heroic measures should be discontinued. His remark was widely construed as an invitation to the elderly to leave by the nearest exit, and it provoked an uproar. Florida Representative Claude Pepper, 83, a leading spokesman for the elderly, accused the governor of "downgrading the elderly." Others angrily demanded Lamm's resignation.

"At what point should life-sustaining treatment be discontinued? What value do we put on saving a human life, on reducing pain, on extending the lifespan?"

Who Should Choose?

Yet with each new advance in medical technology the issue grows more important: at what point should life-sustaining treatment be discontinued? On one level, this is a question that physicians need to address. Perhaps they should be more selective in admitting terminally ill patients for whom the life-sustaining capabilities of an ICU represent nothing more than a means of prolonging suffering. But at a more fundamental level, the issue here is a value question that we all need to

address: what value do we put on saving a human life, on reducing pain, on extending the lifespan? How do those values change when the life at stake is a relative's, a neighbor's, a stranger's?

Is the same aggressive treatment that is routinely pursued with a 35-year-old appropriate with an 80-year-old? If not, which medical procedures should be denied to the elderly? Other countries have begun to confront this question. The British National Health Service, for example, has a policy of not providing hemodialysis to people over 65, and Sweden routinely denies expensive organ transplants to people over 65. In order to contain soaring medical costs for the society as a whole, we might agree to such rationing. But how would we feel if the elderly person who needed that organ transplant were our own parent, our spouse, our friend — and furthermore if that person were otherwise in perfectly good health? What if that person were you?

Britain's experience with strict budget limits on its National Health Service suggests what it might mean in the United States to begin rationing medical assistance. If American doctors followed the example of their British counterparts, they would weigh not only the medical aspects of diagnosis and treatment but also the patient's age, general health, family responsibilities, and chances of recovering. That, as Henry J. Aaron and William Schwartz, authors of a recent study of the British system, point out, "would require a far-reaching change in attitude for many American doctors who believe it unprofessional, if not immoral, for doctors to consider costs in deciding what actions to take on behalf of patients."

Aaron and Schwartz point out that if rationing were applied in this country — if budget limits prevented physicians from doing everything in their power to treat fetal defects, for example, or to sustain the lives of those with irremediable medical problems — one probable result would be a substantial increase in the number of malpractice suits. Some people would allege that hospital rules denying treatment in certain cases are capricious, that arbitrary decisions violate our right to equal protection under the law. In Britain not many malpractice suits are filed because that country's tort system differs substantially from our own. British claimants have to pay out of pocket for a lawyer's services, regardless of the outcome of the case. If the case is lost, claimants may have to pay for the defendant's costs as well. In this country, attorneys typically take one-third of the award if they win, and receive nothing if they lose.

So one substantial obstacle to redefining standard medical practice and offering something less than the best possible treatment to everyone would be the threat of a flood of malpractice suits that could — in Aaron's and Schwartz's words — "choke the courts and paralyze medical practice." What might be necessary, if we choose to contain medical costs by rationing medical treatment for some purposes and some patients, is a change in the laws that now encourage people to sue doctors and hospitals if they feel that medical treatment has been withheld or poorly performed.

New technologies have substantially increased the cost of medical care. One way to contain those costs would be to agree upon certain limits to their use when it is clear that costs outweigh benefits. In this country, as in Britain, doctors might be encouraged to develop rules of thumb to distinguish extravagant care from standard medical practice. That is what many people propose as the most promising approach to contain medical costs. They believe that much of what is now done in the name of "standard medical practice" is unnecessary and excessive — and that if we were to cut back on the use of certain procedures, we wouldn't be forced to accept cutbacks in *other* areas of social spending.

But that means deciding which potentially beneficial equipment — such as CT scanners — hospitals should *not* be able to purchase. It means deciding which services — such as organ transplants — should *not* be performed so often. It means deciding when life-sustaining measures should *not* be applied. And those are decisions that can't be made by the medical profession alone.

5

Putting a Priority and a Price Tag on Health Care

> **"Thinking about what is in the public interest requires both patients and health care providers to weigh in a humane fashion the cost and benefits of medical care."**

Early in the summer of 1984, there was some good news for a change about health care costs. While the price of medical care was still rising faster in the first half of the year than that of most goods and services, the rate of inflation in medical care dropped to 6.5 percent, almost four points lower than it had been in 1981. Commenting that the country has "broken the back of the health care inflation monster," Secretary of Health and Human Services Margaret Heckler attributed the progress to the new Medicare reimbursement scheme that pays fixed amounts for each medical procedure. While not everyone would agree that the new reimbursement scheme, by itself, represents a cure for soaring health care costs, few would deny that its restraining effect is important.

There are other signs of progress. In Iowa, which just a few years ago was troubled by health care costs that strained the state's budget and the ability of employers to keep up with rising health premiums, a concerted statewide plan has led to dramatically lower hospital admissions and thus to lower health care costs. As a result of declining use of hospital beds by Blue Cross and Blue Shield subscribers, that company announced that as of July 1, Iowa subscribers would benefit from the first general reduction in health insurance rates since rapid health care inflation started.

What happened in Iowa is a reminder that something can be done about the problem. Across the country, various steps are being taken to attack it. Yet the problem of soaring costs is by no means solved. In many regions, health care costs are still increasing at twice the rate of inflation. Although various proposals have been made to solve Medicare's crisis, there are still real questions about how to close the huge gap that will open within a few years between that program's revenues and its projected outlays. Further, because of new medical technologies, and the aging of the population, health care costs are likely to continue their inexorable rise.

How do we gain control over this troubling situation? It is not enough for us — either as individuals or as a society — to say that we want the highest-quality care for all. As the cost of doing all that medical science is capable of doing has become more apparent, many Americans have begun to confront the necessity of choice.

Perhaps the first point to recognize is that the various things we want in a health care system are not compatible with each other. As we have seen, many people feel that no one should go without medical care because of their inability to pay. These people want a health care insurance system that prevents financial hardship in the case of a severe illness or accident. Yet many of them also want a system that makes efficient use of resources and that discourages excessive or unnecessary use of the medical system. Most people want to avoid a large tax increase that might be imposed to solve the Medicare crisis, yet they don't think the elderly should pay more of their medical costs out of their pocket. People want cutbacks in government spending,

Gene Maggio/The *New York Times*

but they don't want cutbacks in Medicare or Social Security, the two programs whose costs have been rising more rapidly than any others.

Such incompatible wishes are one reason why it is so difficult to contain health care costs. Coming to a decision forces us to confront the high costs of medical services that many have come to regard as a right. Coming to a decision forces us to choose our priorities, and to recognize that we may have to give up certain things in order to get those that we regard as more important.

How can the health care system be made both efficient and effective? Can we encourage both patients and health care providers to weigh with compassion the benefits and costs of medical care? These are the problems we face.

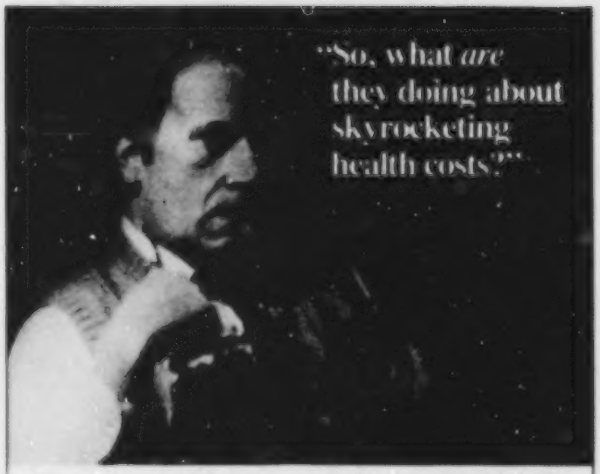
Choices and Consequences

Basically, there are just two ways to resolve the problem. Our first choice is simply to accept the high and growing costs of health care. Some people feel that health care is so important that cost should be no consideration, that all cost-cutting measures are unacceptable because they deprive some patients of the care that they need. As expensive as health care is, they feel that it's worth it. After all, because of the money that we've invested in health care over the past generation, we have new equipment and new drugs that give people a better chance of fighting off diseases that once were fatal. Because of the funds that have been committed to government-subsidized medical programs, we are taking better care of older citizens and the poor than we did in the past. Now, if this is our choice, the problem is: who should pay for it? And which of our other national goals might have to be scaled down in order to pay the high cost of medical care?

Our second choice leads to equally difficult decisions. Considering the strain that soaring health care costs place on government budgets, on employers, and on individuals, we could decide that limits should be imposed. But doing this means redrawing the "contract" specifying the kind of medical care people are entitled to, and how much they will pay for it.

As we have seen, three fundamentally different cost-cutting strategies have been proposed. Some people feel that the basic problem is that neither patients nor providers have an incentive to think about costs. From this perspective, the best hope for containing cost is to make medical care once again an economic good. Patients should be required to pay larger deductibles and co-payments in order to discourage unnecessary use of medical facilities. There might be greater incentives for people to join HMOs and other types of health care systems that provide an alternative to fee-for-service medicine. Employees might be given a choice among health care plans as an incentive to shop around. In brief, one way to bring costs down would be to make both health care consumers and providers more cost conscious, to make shopping for medical care more like the shopping we do for other goods and services.

A second cost-cutting strategy is based on the view that health care costs have increased so rapidly since the mid-1960s because government-subsidized programs — particularly Medicare and Medicaid — have been too generous, creating a very



They're asking you what you think

If not why's ever asked you what you think about an issue as important as skyrocketing health costs, here's your chance. They might not ask again. ____ are so concerned about the rising cost of health care in ____ that they need to know what you think about it.

That's why ____ is asking you to take part in ____ HealthVote campaign.

It's Easy To Take Part

Over the next six weeks, watch for special features and news stories, as well as HealthVote ads, alerting you to the choices ____ans face as we try to stem the rising cost of health care.

It's Hard to Decide

The choices are difficult. Should we pay higher deductibles, close hospitals, or cut back on care for the elderly, for instance.

HealthVote will explain the choices, showing you the pros, the cons, and the consequences of each one. HealthVote, however, won't tell you what to choose. That's your job.

So Vote on ____: You Will Be Heard

On ____ the ____ will publish a ballot listing each of the choices open to ____ ____ans who want to cut rising health costs. Think carefully about everything you've heard during the campaign and then mark your choices on the ballot. Send it back and we'll publish the results.

After six weeks of thinking, talking, arguing, and voting, you will be heard. Come to think of it, in a democracy like ours, that's just as it should be.

HealthVote

It's your turn to choose.

A lively debate about health care costs has begun. This ad is appearing in local newspapers in various communities which are participating in a "Health Vote" campaign designed to encourage citizens' participation in decisions about health care costs and alternatives.

costly entitlement. In this view, Americans have been encouraged by these programs to regard medical care as a free good. Individuals have not had to acknowledge the cost of the services they consume.

For the people who regard government-subsidized programs as the chief reason for soaring health care costs, the most promising solution is to put tighter reins on Medicare and Medicaid. One way of paring down the cost of these programs, as we noted, would be to have the poor and the elderly pay a larger share of their medical expenses. Another would be to change the nature of the coverage, to cut its cost by redefining its purpose. If the elderly paid most of the cost of routine medical care out of their own pockets, while receiving in exchange the assurance that costs of long-term hospitalization would be covered, overall costs would be lowered.

Because such proposals would cut existing Medicare benefits and force people to pay more from their own pocket, they are staunchly opposed by many. An alternative that many favor is to impose cost controls in order to stop doctors and hospitals from increasing the prices they charge.

The third cost-cutting strategy that we examined assumes that the chief factor pushing up health care costs is the sophisticated medical technologies and heroic measures that provide a level of medical care not formerly possible. The availability of organ transplants, intensive care units, and extraordinarily expensive diagnostic tools like CT scanners raises questions that are increasingly important. Does every American have a right to the best health care available? Should heroic measures such as organ transplants and aggressive treatment in intensive care units take place so often? Is it in the public interest to encourage the development and installation of state-of-the-art medical technologies no matter what their cost, or how few patients might benefit from them? If progress is to be made in containing health care costs, citizens have to begin grappling with questions such as these.

Establishing Priorities

Beyond these specific proposals, there are two issues that force us to define our values. The first is how much equality we want and what we are prepared to sacrifice to achieve it. While many of the participants in the health care debate feel that the main problem is cost, others feel that we should not refrain from doing what is right in the name of economy and efficiency. They believe that at a time when at least 20 million Americans lack health care insurance, our primary concern should be to extend to them the coverage that everyone else enjoys — and *then* figure out how to pay for it.

The second issue is what priority we want to assign to health and health care. How important is our own health, our neighbor's, or that of millions of other Americans? While it is often asserted that quality health care is a right and that a person's health is more important than anything else, that still doesn't answer a very practical question: how much health care is enough? With regard to extraordinarily expensive medical procedures such as organ transplants, we have to ask: how should scarce resources be rationed? In which cases are the high costs of heroic measures not justified?

As health care consumers, we are encouraged by a third-party payment system not to think about the cost of the services we consume. But as participants in the debate over health care cost, we are obliged to keep those costs in mind — and to remember that resources could be used to satisfy other goals. The various choices we have examined would help to contain the soaring cost of health care. But they would also reduce the access of some people to medical services, or impose on individuals more of their expense. It is essential that the public join the debate about health care costs because it is the public's health — and in a larger sense, the public good — that is at stake.

For Further Reading

For a comprehensive and insightful account of how the American health care system evolved to its present form, see Paul Starr's *The Social Transformation of American Medicine* (New York: Basic Books, 1982). Many of the questions raised in this issue book — on such matters as third-party payments, the "right" to health care, limiting expenditures on health care, and the high cost of medical technologies — are explored in a useful anthology, *The Nation's Health*, edited by Philip R. Lee, Nancy Brown, and Ida Red (San Francisco, Boyd and Fraser, 1981). Victor R. Fuchs has put together a brief and thoughtful essay on the choices this nation faces regarding health care in *Who Shall Live?* (New York: Basic Books, 1974).

For a profile of some ways in which individuals are affected by the high costs of medical care, and of the health care industry as big business, see Edward M. Kennedy, *In Critical Condition* (New York: Simon and Schuster, 1972). In its "Health Report" series, the *National Journal* has presented a series of informative pieces on the politics of health care reform. See in particular, "Medicare on the Critical List," by Linda Demkovich, *National Journal*, July 30, 1983. For a useful overview on Medicaid, see Thomas W. Moloney's *What's Being Done About Medicaid?* (New York: The Commonwealth Fund, 1982).

Acknowledgments

Many people participated in the process of deciding upon this year's topics, discussing how they should be approached, preparing the materials, and reviewing their content. In addition to the people listed on the credits page, we would like to acknowledge the assistance of the following individuals. David Mathews and Daniel Yankelovich once again provided both guidance and encouragement. Jon Kinghorn played an indispensable role in keeping the various parts of this far-flung network in touch with one another, and providing assistance of many kinds to the convening institutions and forum leaders.

In addition, we gratefully acknowledge the assistance of Stephen Waxman, M.D., for his advice and critical reading, and that of our colleague Jeffrey Tuchman for many useful comments and suggestions. We have drawn upon the experience of our colleagues who planned and carried out a community-wide HealthVote campaign in cooperation with a variety of organizations and institutions in Des Moines, and would like to take this opportunity to thank them for their assistance.

We would like to acknowledge, too, the able assistance provided by Shelly Weinstein, Richard Wegman, Rob Lehman, and John Buchanan, who helped to elicit various viewpoints. As we were deciding how to approach these topics, many individuals were generous with their time and advice, particularly Representative Henry A. Waxman, Representative Barbara A. Mikulski, and Representative Edward R. Madigan.

NATIONAL ISSUES FORUM: RELATED MATERIALS

The following materials may be ordered for use with the 1984 National Issues Forum. Please specify quantities for each item in the space provided, fill in complete mailing address, and enclose check payable to: Domestic Policy Association. Orders must be paid in advance.

Quantity	Issue Books	Cost Per Unit	Total Cost
_____	The Soaring Cost of Health Care	$3.00	_____
_____	Jobs and the Jobless in a Changing Workplace	$3.00	_____
_____	Difficult Choices about Environmental Protection	$3.00	_____
	Discussion Outlines (One page, printed on both sides.)		
_____	The Soaring Cost of Health Care	Bulk Orders 100 for $5.00	_____
_____	Jobs and the Jobless in a Changing Workplace	Bulk Orders 100 for $5.00	_____
_____	Difficult Choices about Environmental Protection	Bulk Orders 100 for $5.00	_____
	Reprints of the Questionnaire		
_____	The Soaring Cost of Health Care	Bulk Orders 50 for $5.00	_____
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_____	Difficult Choices about Environmental Protection	Bulk Orders 50 for $5.00	_____
	Videotapes		
_____	The Public and Public Policy 1984 (Overview of DPA/NIF and the Presidential Library Conferences) Format (Check one) ☐ VHS ☐ U-Matic	$50.00	_____
_____	Forum Starter Tapes (10-15 minute summaries of all the issue books on a single video cassette)	$50.00	_____
	General Promotion Publications		
_____	Overview Brochure "The Domestic Policy Association 1984"	Bulk Orders 50 for $5.00	_____
_____	Flyer with Order Form "A Different Kind of Vote"	Bulk Orders 50 for $5.00	_____
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	Posters		
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NATIONAL ISSUES FORUM

2. The Soaring Cost of Health Care

Please answer these questions after you have attended the discussion or read the booklet. Answer them without reference to your earlier answers. Then hand in both reports to the forum moderator, or mail them to the Domestic Policy Association in the attached prepaid envelope. (In case no envelope is enclosed, you can send these pages to the Domestic Policy Association at 5335 Far Hills Avenue, Dayton, Ohio 45429.)

Part I:

For each item below, check the appropriate box to indicate if it is something

- ☐ we should do *now*
- ☐ we should do *only if* health care costs keep rising faster than inflation
- ☐ we should *not* do under *any* circumstance

Proposals:	**Should Do Now**	**Only If**	**Should Not Do**	**Not Sure**
A. Introduce more competition into the health care system:				
1. Establish higher deductibles so that patients pay more of their medical bills before insurance coverage begins **PRO:** Would remind people that health care is something we pay for one way or another **CON:** Family budgets could be strained, especially in the short run, and some might put off seeking the care they need	☐	☐	☐	☐
2. Provide workers with a choice of insurance plans and incentives to shop for the insurance they need **PRO:** Would put pressure on insurance companies to be more competitive and offer better values **CON:** Called a "bribe for employees to disinsure themselves" because those who need the money might opt for inadequate coverage	☐	☐	☐	☐
3. Encourage people to join HMOs—Health Maintenance Organizations **PRO:** HMOs have a record of providing good health care for a lower price **CON:** Patients would have to give up their family doctor	☐	☐	☐	☐
B. Limit health care costs through government initiatives:				
4. Regulate costs by imposing limits on how much doctors and hospitals can charge **PRO:** This would be the most direct way to contain costs **CON:** Hospitals and doctors might cut back on the quality of care they provide	☐	☐	☐	☐
5. Make all Medicare and Medicaid recipients pay more of their own bills before coverage begins **PRO:** It would discourage unnecessary use of the health care system **CON:** Might prevent some people, especially the poor, from seeking the care they need	☐	☐	☐	☐
6. Impose higher deductibles on Medicare recipients with higher incomes **PRO:** It is fair to make those who can afford to, pay more **CON:** Since we all pay into Medicare, it's not fair for some to get more benefits than others	☐	☐	☐	☐
7. Require Medicaid recipients to use clinics, HMOs, and other facilities with a record of holding down costs **PRO:** Taxpayers should only have to pay for the most efficient forms of treatment **CON:** If the poor are treated differently from everyone else, their care will inevitably become second-rate	☐	☐	☐	☐
8. Raise taxes to pay the increasing costs of Medicare and Medicaid **PRO:** Any cutbacks in these programs would jeopardize peoples' health **CON:** Unfair to raise taxes when many of the elderly can afford to pay more themselves	☐	☐	☐	☐

Proposals:	Should Do Now	Only If	Should Not Do	Not Sure
C. Limit heroic measures to contain costs:				
9. Relax malpractice laws to encourage doctors to perform fewer diagnostic tests and practice less "defensive" medicine	☐	☐	☐	☐
PRO: Both "defensive" medicine and the cost of malpractice insurance add to health care inflation — **CON:** Takes away a patient's right to sue, the best protection people have				
10. Define strict criteria about who is eligible for very expensive treatments such as organ transplants	☐	☐	☐	☐
PRO: Those who would derive the most benefit would still get these procedures — **CON:** Some people will be deprived of life-saving care				
11. Put strict limits on hospitals' ability to buy expensive technology such as CT scanners	☐	☐	☐	☐
PRO: Such equipment is usually available in nearby hospitals — **CON:** Such equipment might not be there for those who need it				

Part II:

For each of the following, mark whether you favor or oppose this measure.

	Favor	Oppose	Not Sure
12. Institute a national health insurance program that would guarantee health insurance for all Americans	☐	☐	☐
13. Expand Medicare to provide catastrophic illness protection to all recipients	☐	☐	☐
14. Expand Medicare to cover the cost of prescriptions, eyeglasses, and hearing aids	☐	☐	☐

Part III:

Background Questions

15. Which of the following DPA activities did you participate in?

- Read the booklet ☐
- Attended a forum ☐
- Both ☐
- Neither ☐

16. Did you participate in a DPA forum *last* year?

- Yes ☐
- No ☐

17. Did you (or will you) participate in DPA forums on other topics *this* year?

- Yes ☐
- No ☐

18. Which of these age groups are you in?

- Under 18 ☐
- 18 to 29 ☐
- 30 to 44 ☐
- 45 to 64 ☐
- 65 and over ☐

19. Are you a man or a woman?

- Man ☐
- Woman ☐

"I know no safe depository of the ultimate powers of the society but the people themselves; and if we think them not enlightened enough to exercise their control with a wholesome discretion, the remedy is not to take it from them, but to inform their discretion by education."

Th Jefferson